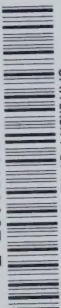


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THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
JOURNAL DE L'ASSOCIATION CANADIENNE
DES HYGIENISTES DENTAIRE

PROBE

VOL 28, NO 1

JAN/FEB 1994 JAN/FÉV

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Maureen Bowerman (at left)

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Who's Doing the Talking?

Roles and Stories

By:
Dianne Landry, RDH, MDN, BA, BVTEd

What is a Dental Hygienist? What is it that you do exactly?"

Every hygienist has been asked these questions repeatedly. Why, after 44 years of existence in Canada, are we still explaining our role to our clients, our employers, and to ourselves? The answer is simple! Dental Hygiene is a dynamic, evolving, and progressive health care profession.

The identification of the role of a dental hygienist is often linked to the particular setting in which the hygienist practices, the most visible being a clinician in the neighborhood dental office. But that vision is changing!

Dental Hygienists fulfill many roles. Participants at a workshop charged with the task of clarifying and defining the vision of Dental Hygiene for the year 2005, focused on a hygienist's key responsibilities as a means of self-definition. They concluded that these responsibilities include all of the following: clinical therapy, health promotion, education, administration, and research. The degree to which each individual dental hygienist focuses on each responsibility or "role" is dependent on the practice environment.

Throughout our lives, we initially learn our roles from the outside in, as a means of fulfilling specific social roles in a manner that is consistent with the established cultural traditions. We learned the traditional dental hygiene role in this same manner. We all have anecdotal evidence of the expected norm of behavior and skill proficiency learned at the knees of our beloved instructors in Dental Hygiene School. Our educational institutions have taught us the rudimentary skills which enable us to act as clinicians, educators, health promoters, administrators, and researchers. But each one of us, through life experiences, informal and formal learning, has refined these skills in order to create an individual identity which gives personal meaning to our lives and vocations.

Every hygienist has modified, integrated and deleted aspects of the traditionally ascribed roles to better fit with the way we



DIANNE LANDRY, RDH, MDN, BA, BVTEd

want society to see us. Thus, in order to answer "What is a Dental Hygienist?", each one of us has created a unique perspective. This powerful creative force brings with it the ability to elevate the level of expertise, professionalism and thus, the quality of care that we provide our clients.

In order for the practice of Dental Hygiene to continually transform itself, adapting to the ongoing nature of social change, we must individually as well as collectively examine and critique our practice. In a collaborative journey, we can assess our various roles in search of more effective and humane means of enacting them as part of this quest for self-identity.

One of the ways in which this can be accomplished is by sharing our personal stories.

Storytelling is a way to make sense of our lives, in this case our occupational lives. A key notion in storytelling is the constant retelling and reconstruction of our story. We do this in an attempt to make our personal story roughly fit society's expectations of our role. We are constantly holding up the traditional practice of Dental Hygiene as a measure of how far we have

strayed and how much farther do we dare extend the parameters of our practice before we exceed the boundaries of the established canons of Dentistry. At the same time, our search for a meaningful and rewarding profession pleads for a transformation of the larger institutional story of Dentistry to reflect our own contribution to its evolution.

Stories about how we should act always originate externally, for example in dental hygiene school, and then are internalized by the individual to be either accepted, rejected or reconstructed. In other words, learning occurs from the outside in and subsequently, from the inside out. We experience things first and then we reflect on our experiences. There has been and there still is a tension-filled relationship between these two stories — the culturally accepted one and our own exceptional one. This tension is good! It holds the potential for individual as well as collective social change as we strive to understand and overcome the conflict.

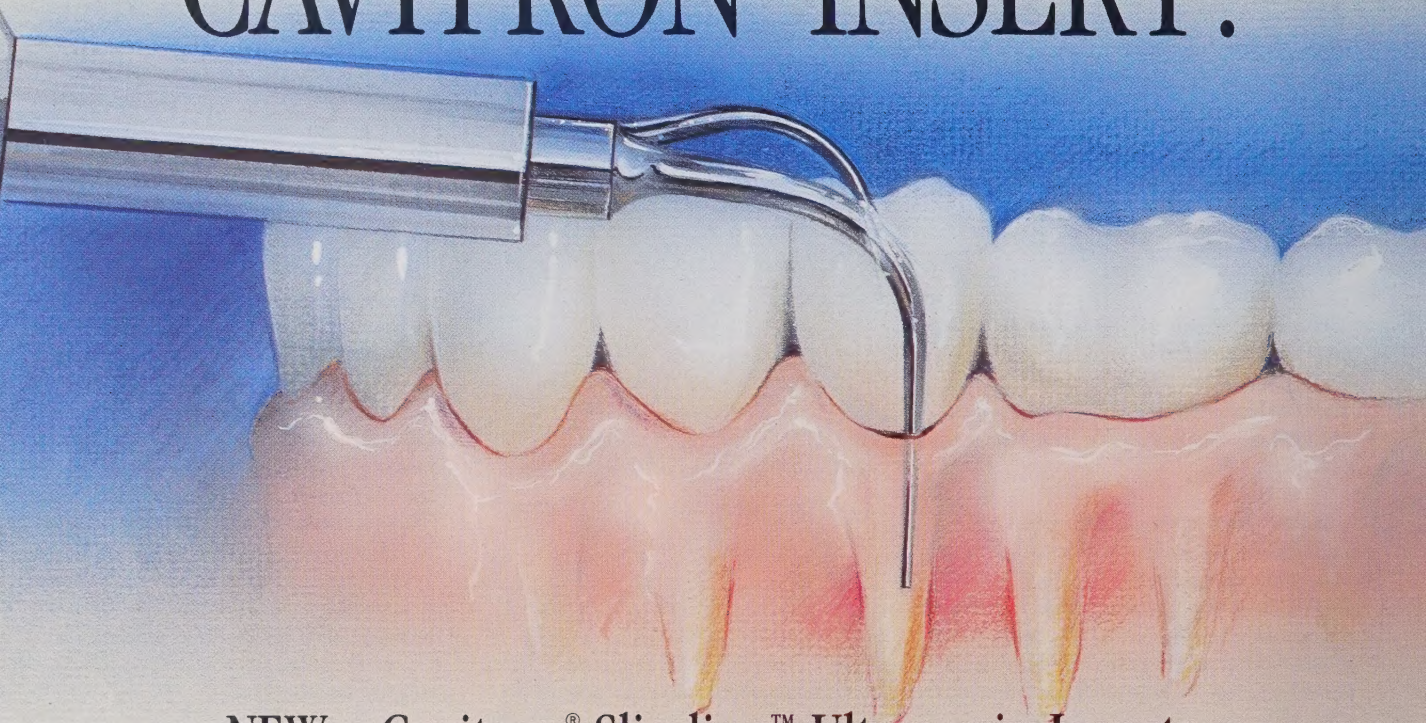
Through storytelling, we are able to teach ourselves, conserve our memories and add to them. In this way we can alter the past, its impact on our present action, and ultimately our future.

What is your exceptional story? How has the telling, retelling and reconstruction of your story helped you search for an understanding between the traditional story of Dental Hygiene and the one in which you feel most comfortable? Your learning experiences are revealed by your stories.

Let us share with each other our exceptional stories. Through this process we can help each other verify our understanding of Dental Hygiene practice, ease the conflict of the tension-filled relationship with traditional beliefs and effect a qualitative change that will benefit the practice of oral health care, the practitioner and most importantly, the client.

Send your story to the Editorial Director, Probe, CDHA, 1018 Merivale Road, Suite 201, Ottawa, ON, K1Z 6A5.

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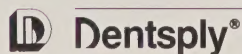
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COVER

This month our cover features colleague, **Maureen Bowerman**, who graduated in 1980 from SIAST (Saskatchewan Institute of Applied Sciences & Technology) in Regina, SK. She has worked in public health as a dental therapist in the Saskatchewan Dental Plan, as an educator in the Dental Assisting Program at SIAST, Kelsely Campus in Saskatoon, and in clinical practice. Presently she is the Conference Coordinator for the 1994 CDHA 5th Professional Conference to be held in Saskatoon June 17-19, 1994. Pictured with her are (from right to left) **Barb Long**, President of SDHA, **Caroline Yelland** and **Shelly Ruiters** who are also on the Conference organizing committee. They invite you to "Sharpen Your Professional Edge" in Saskatoon in June.

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We look forward to serving you.

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A white toothbrush with a blue textured grip and a flexible neck. The neck is shown in a blurred, curved position to demonstrate its flexibility. The head of the brush is white with dual bristles. The word "Aquafresh" is printed in blue on the handle.

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On Turning Thirty

A new year: 1994! An exciting year for dental hygiene in Canada. During this year the Canadian Dental Hygienists Association will celebrate its 30th birthday. Turning 30 has always been considered a milestone. Many of us remember feeling a little trepidation as the big day approached; for some of you that is still in the future. CDHA celebrated its 25th birthday in Ottawa in conjunction with the International Symposium. At that time we knew that dental hygiene had definitely "grown up". As CDHA approaches 30, we know that we have definitely matured!

Think back over the past five years — look at what has happened to our profession. The majority of dental hygienists in Canada now control their own destiny. Yes, self-regulation is a reality! Did we really believe in the possibility five years ago, or did we think we were just dreaming? Self-regulation exists in Quebec, Alberta, Ontario, and (hopefully by the time this is printed) British Columbia. The other provinces are at differing stages in their goal towards self-regulation, but each provincial association has placed it high on their priority list. The dream is coming true.

Five years ago, in conjunction with our 25th birthday, CDHA restructured into the council system. We did not know then how positive that move would be, but the visionaries knew that in order to progress, our organization had to change. At first, some found that change painful. Change often is. However, one of the major benefits of the council system has been to support current governing practices which state that Board members, while coming from different regions/territories, govern as a whole. The Council members must consider all dental hygienists in all circumstances throughout the country. Today, all councils work together as a unit to identify short and long term goals which meet the CDHA Mission statement. Composed in 1964, our mission statement has stood the test of time! The councils have regional representation, ownership of the projects they undertake, and have been exceptionally creative, innovative, and effective. Many provincial associations are now moving towards this model.



FRAN RICHARDSON COTTON
RDH, BScD, MEd

This year CDHA will offer its fifth professional conference for dental hygienists. The theme is ethics: "Sharpen your Professional Edge: A Question of Conscience — A Matter of Choice". The decision to offer our own conference, separate from our dentist colleagues, presented an ethical dilemma for some of our members. But as we mature, we must assume a greater responsibility for our own professional development. Today, dental hygienists feel welcome to attend conferences sponsored by other health professionals, but they can now choose to attend a conference dedicated to their own special needs. The CDHA conferences are proving to be a great success.

The level of sophistication of our association has grown in its ability to develop and articulate policies, practice standards, and more frequent and higher quality publications. These vehicles have enabled CDHA to enhance communication with government, other health care professionals, and dental hygienists at home and around the globe. Our association has increased its profile to the extent that Central Office is experiencing increased demands, thereby necessitating a comprehensive review. This is a welcome consequence of taking charge of our own destiny.

Our growth as a national organization is reflected by the fact that regional events and occurrences impact on the profession as a whole. As a national entity, CDHA is recognized by government and other professional associations as the official voice of dental hygiene in Canada. Just a few years ago, outside agencies might have gone elsewhere to learn about the dental hygiene profession. Today, those agencies turn to CDHA.

Another sign of maturity is when other professionals seek your expertise. Sponsoring agencies now look to us to partner with them during special events. The financial commitment of our corporate sponsors assists the efforts of individual dental hygienists in promoting oral health to the many diverse groups we now reach during National Dental Hygiene Campaign. This collaborative effort will ensure the continued success of this worthwhile endeavor.

A birthday is a time of celebration and a time of reflection. As we prepare to celebrate thirty years as an association, let us not forget to thank the numerous volunteers who have contributed their time and talent to the development of our organization. Without dedicated volunteers, CDHA cannot function. As we prepare to light the candles in June in Saskatoon, keep in mind that 30 is still very young in terms of growth and maturity as a national organization. There are many more lessons to learn and goals to accomplish. Thirty is just beginning!



Fran is currently Chair, Division of Dental Studies, College of New Caledonia, Prince George, BC. She received her Diploma in Dental Hygiene from the University of Toronto in 1971, a BScD from the University of Toronto in 1982 and a Masters in Education from the University of Regina in 1987.

North American Research Conference in Niagara Falls

Dear Editor:

Thank you and congratulations to Ellen Brownstone, Dale Scanlan, and the rest of the CDHA organizing committee on a terrific North American Research Conference! There was obviously a tremendous amount of effort expended to ensure that the program proceeded virtually without a hitch.

Like most participants, I was absolutely overwhelmed by the array of presentations available. I was impressed by the calibre of the presentations and was excited and proud of the advancement that dental hygienists are making in our profession. I will be sharing some of my experiences with readers of our Bulletin in an upcoming article and encouraging dental hygienists to plan to attend the conference in Saskatoon.

Mary Banford, Dip DH, BA
Manager of Allied Dental
Personnel Services
College of Dental Surgeons
of British Columbia

Dr. Thordarson's letter...

Dear Editor:

This is a reply to a letter written by Dr. G.R. Thordarson, DMD, Executive Director, College of Dental Surgeons of B.C., published in *Probe* (Volume 27 No. 5). While it is encouraging to see a member of a dental association expressing their views in a dental hygiene journal, I have a couple of concerns I would like to raise.

In the letter, Dr. Thordarson implied that dental hygienists have a body of knowledge that does not go beyond scaling and root planning. If he and other dental professionals are not familiar with the comprehensiveness of our knowledge base and the scope of our practice, then we, as dental hygienists, have a big job ahead of us! People need to be educated (to the fact) that dental hygienists, as primary oral health care providers, have more to offer than just being able to remove calcareous deposits from the supra gingival and sub gingival surfaces of the teeth.

My second concern was the reference to *Probe* as a magazine. I am sure this is an oversight on Dr. Thordarson's part, but I would like to emphasize that *Probe* is indeed a scientific journal that CDHA works very hard to produce. It can be found in dental and dental hygiene libraries across Canada and can be an effective tool in the education of the public and the dental community.

On the positive side, I was glad to see that Dr. Thordarson acknowledges that there are many difficult issues facing dental hygienists today. These are indeed our issues and therefore we, as dental hygienists, are responsible for initiating and implementing solutions. It is my hope, however, that dental and dental hygiene regulatory bodies will work together to address employment, ethics, and other common issues.

Terri-Lynne Martin, RDH

Membership has its privileges...

Dear Editor:

Recently I was asked why I decided to join CDHA/ODHA almost ten years ago and why I maintain my membership at the present time. Since I graduated in 1966, why did it take so long for me to join in the first place?

When I first worked as a dental hygienist every position was specially negotiated. Few dentists wanted dental hygienists or knew what the potential benefits to the practice would be. I felt that I had to make my own way, fight my own battles over responsibilities, wages and benefits, with little or no support from other hygienists. This was particularly true in rural settings.

In the late 70's, I had the good fortune to become involved with the Girl Guides of Canada, an organization that provided a model of support in training, job descriptions, terms of reference, progressive responsibility, mentoring and networking. For the first time I gained an understanding of the value of an organization. However, I lived in a rural area, about an hour's drive from the nearest component society. It was difficult to work all day, then drive to an evening meeting and still be fresh for work the next day. This is still a problem for many dental hygienists.

In 1983, my family transferred to the Oshawa area and a colleague invited me to my first ODHA spring meeting. I was impressed with the level of leadership displayed and I subsequently joined.

Recently I attended a meeting offered by the Ontario Ministry of Culture, Tourism and Recreation. There I learned that people are *self-directed* to join and maintain membership in organizations for three reasons. They are: 1) for the sense of achievement or accomplishment that membership activities supply, 2) for the sense of affiliation or camaraderie with like-minded individuals, and 3) for the sensation of participating in membership projects or services. The facilitator noted that most people join for two of the three reasons and that their reasons may change over time.

In my case, I believe I joined for the first two reasons and now stay in order to assist a profession that I am proud of. This assistance is most urgently needed now to deal with the pressures created by a strained economy, the move toward self-regulation, changes in the scope of practice due partially to a decline in the caries rate, new technologies and greater numbers of allied health professionals entering the dental profession. Dental Hygiene needs a strong voice to speak on its behalf.

So, why did I finally join at that time? I believe I had to grow in my understanding of the purpose and structure of organizations before I could appreciate their importance. I also submit that CDHA/ODHA had to grow and mature to meet the needs of its members. Conferences and the 1989 International Symposium held in Ottawa have been especially informative and give evidence of the maturity of the organization. This is a tribute to the early members of the organization who had the tenacity to persevere when hygienists like myself did not join.

Why do I maintain my membership? I believe that it is the most important contribution I can make to uphold the credibility, reputation, and role of the dental hygienist that I and others have struggled so hard to attain after graduation. Any other benefits are like icing on the cake, nice to have but with little substance of its own.

Pat Spencer, RDH, BA

Call for Applicants: The CDHA/Procter & Gamble Graduate Student Research Award

OBJECTIVE: To promote the research training of Canadian dental hygienists in research oriented Masters or Doctoral programs.

GENERAL DESCRIPTION: An award of \$5000.00 will be given annually to a highly qualified candidate enrolled as a graduate student in a Masters or Doctoral program.

ELIGIBILITY: Applicants for this award must be Canadian dental hygienists who are active, associate, student or life members in good standing of the CDHA who may be studying full or part time. Applicants must present evidence of having been accepted by a recognized academic institution.

APPLICATIONS: The deadline is April 1 of the year in which the award is to be given. Applications must be submitted on forms available from the CDHA Central Office.

DURATION: This award is made for one academic year for full-time students or the equivalent for part-time students. The award may be renewable for one additional academic year or its equivalent on receipt of a satisfactory progress report. The progress report must detail work to date and include any preprints or reprints arising from the work. Any request for renewal of this award should be accompanied by a letter from the research supervisor and one other referee.

CONDITION OF SUPPORT: On completion of studies, recipients of this award agree to provide a bound copy of the thesis or project to Central Office.

For further information and application forms please contact:

Canadian Dental Hygienists Association
1018 Merivale Road, Suite 201
Ottawa, Ontario K1Z 6A5

National Dental Hygiene Week

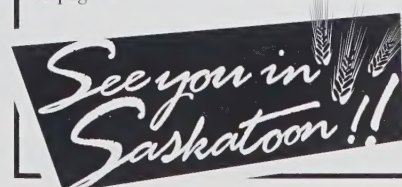
The dental hygiene students at George Brown College celebrated National Dental Hygiene Week Oct. 93 by promoting dental health education. Staff and students at the college received information packages and oral health care aids emphasizing the continued commitment of the students to community oral health.

Watch for a complete report on NDHW '93 in the March/April issue of *Probe*.



Pamela Wallin

...will join us in June to *Sharpen Your Professional Edge* — details on page 34.



Call for Applicants: Canadian Dental Hygienists Association Dental Hygiene Research Grant

OBJECTIVE: to support Canadian dental hygienists engaged in research which enhances the dental hygiene profession's ability to promote health and well-being.

GENERAL DESCRIPTION: A grant of \$5000.00 will be awarded annually to a Canadian dental hygienist involved in qualitative or quantitative research as a principal investigator or co-investigator. Preference will be given to research projects relevant to the discipline of dental hygiene and the goals of the CDHA.

ELIGIBILITY: Applicants for this grant must be academically qualified Canadian dental hygienists who are active or life

members in good standing of the CDHA. Evidence of academic credentials at the Masters or PhD level is required.

APPLICATIONS: The application deadline is March 31 of the year in which the grant is to be awarded. Applications must be submitted on forms available from the CDHA Central office.

For further information please contact:

Canadian Dental Hygienists Association
1018 Merivale Road, Suite 201
Ottawa, Ontario
K1Z 6A5

CDHA Awards of Excellence!

On Saturday morning at the North American Research Conference Margo Grafstein of SmithKline Beecham presented the student Aquafresh awards to Christy Cessford, Paul



Aileen Seed (left) with Paul Green, Natasha Kravtsov and Christy Cessford



Margo Grafstein (left) with Aileen Seed, MSC Chair

award winners also receive complimentary registration at the conference. CDHA would like to take this opportunity to thank SmithKline Beecham for their partnership in this program.

The North American Research Conference Saturday luncheon was dedicated to **Procter & Gamble**. James O'Reilly awarded this year's recipient, Linda Mickelson, with the CDHA/P&G Graduate Student Fellowship Award. Congratulations Linda!

Joan Degan, Corporate Relations, spoke of the partnership that has developed between P&G and the CDHA over the last two years. As

well as sponsoring the Graduate Student Fellowship Award, P&G has provided an excellent educational series to every dental hygiene school in Canada, to the provincial associations, and the Canadian Forces dental schools to facilitate continuing education and long distance learning. P & G provides every dental hygiene student in Canada with a congratulatory kit upon completion of their program. P&G was the major sponsor of the 1993 National Dental Hygiene Campaign. They provided a speaker for the research conference and participated in the commercial exhibits. P & G supports our national



Linda Mickelson, Rhonda Lipton and James O'Reilly

journal through advertising. It was Joan's pleasure to present James O'Reilly and Rhonda Lipton of P&G with a plaque signifying an award of excellence for the support that they have given to CDHA.

As James accepted the award, he was able to announce that the Health Protection Branch has recently approved of the use of Peridex in Canada. This statement was met with a rousing round of applause.



Rhonda Lipton and James O'Reilly with Joan Degan

On behalf of the Canadian Dental Hygienists' Association, I would like to thank the Dental Industry and other corporations for their support at the North American Research Conference that was held at Niagara Falls from October 15-17, 1993. Our success was due, in part, to their participation.

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Premier Dental (Sharpening Kit)
Saskatchewan Dental Hygienists' Association (2 T-Shirts)
Teledyne Water Pik (Deluxe Shower Massage)
W.B. Saunders (Book)

Submitted by Joan Degan

The Parent Show

Procter and Gamble shared their booth with CDHA at the Parent Show held in Toronto at the Metro Convention Centre from November 12-14, 1993. Over 200 exhibits were visited by 25,000 people. CDHA Board members, Diane McCambly, Wanda Staples, Lorraine Boomhour and I



CDHA at the Parent Show

Left to right: Wanda Staples, Diane McCambly, Joan Degan and Lorraine Boomhour

addressed the questions and concerns of the visitors to our booth. Fact sheets concerning fissure sealants, fluoride, mouth care for infants, and school-age children, nursing bottle decay and the sugar content of some common foods were also distributed to the parents.

Ash Temple very generously provided CDHA with a dental chair in which over 200 youngsters experienced their first "ride".



This event very successfully profiled the role of the dental hygienist in the delivery of primary oral health care to the public. Consideration will be given to expanding this type of event to other cities across Canada next year. CDHA would like to acknowledge Procter and Gamble and Ash Temple for their assistance in making this event possible. I would also like to thank Diane, Wanda and Lorraine for volunteering their tireless efforts and cheerfulness during the two days.

Submitted by Joan Degan

From Corporate Relations

Dear Fellow Members,

Three years ago, I volunteered for the position of Corporate Relations Officer for CDHA. The following is an update of the activities.

The development of a Corporate Manual was the first project. This manual contains CDHA's goals, guidelines, projects that we would appreciate sponsorship for, and our professional conference data including commercial exhibits. This manual was sent to companies that may have an interest in the Dental Hygiene profession. The manual is updated annually; 1994 is the third edition.

This manual provided the impetus for the initiation of many excellent programs. Aquafresh sponsored the Student Award Program. They provided our members with pamphlets and samples of their new brush. Procter & Gamble (Crest) became partners in our Graduate Student Fellowship Award, provided graduation kits to our Dental Hygiene students, and a sixteen part educational series to the dental hygiene schools and the profession. P & G sponsored our 1993 National Dental Hygiene Campaign by providing the posters, fact sheets and stickers that our members received. They provided 210,000 educational kits which consisted of a teaching manual, the Egg-speriment, Zero Cavity Club kits, CDHA's poster and fact sheets to elementary schools (Gr. 1 & 2) across Canada. The response was overwhelming! There were over 400,000 requests. In an effort to distribute the kits evenly the number requested by health units had to be reduced.

Wrigley also expressed interest in our

N.D.H.C. this past fall. As a result our members received the Barkley Beaver information. Wrigley also set up radio spots in eighteen cities across Canada where CDHA members broadcasted information on helpful hints for Halloween.

Colgate provided financial aid for Canada's representatives to the International Federation of Dental Hygiene.

The manual has elicited the sponsorship and participation of many companies in our professional conferences. We have introduced commercial exhibits at our conferences which is appreciated by both the exhibitors and the members.

The advertising in the *Probe* has increased with the support of the dental corporate industry. Each year will see improvements based on the constructive opinions that have been collected.

P & G provided CDHA with an opportunity to exhibit at a parent show that was held in Toronto from November 12-14, 1993. Ash Temple provided CDHA with a dental chair in which youngsters were able to experience their "first ride". It was an excellent avenue for CDHA to profile the role of the hygienist to the public.

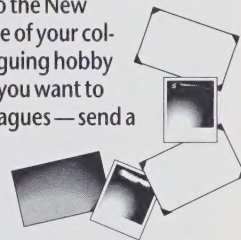
I would like to take the opportunity to thank the dental corporate industry for the support of the profession. All support, whether large or small, helps CDHA to educate our members and the public.

Thank you!

Submitted by Joan Degan



We are interested in receiving photos that can be used on the cover of *Probe*—the theme *Colleagues from Coast to Coast* seems to be a popular one and will continue into the New Year—so if you or one of your colleagues have an intriguing hobby and/or pastime that you want to share with your colleagues—send a photo to CHDA at the address noted above.



MOVING?

Please send your new address to:
CDHA, 1018 Merivale Road, Suite 201
Ottawa, Ontario K1Z6A5
...And don't forget to include
your I.D. number!

Diary of a Research Conference

Thursday, October 14, 1993

7 A.M.

Autumn is my favourite time of year, the season that I like best. I wondered why... and when I thought about it, I realized it was because of a vivid recollection of happy childhood memories of that time of year. It was a time of beginnings, a new school year, new books, new teachers, new friends, new clothes, new ideas to learn, great challenges, excitement.

I find as I sit here waiting for the plane to take off, I am experiencing the same inner twinges of excitement and anticipation. I am going to my first International Research Conference, where I will learn from new teachers, experience new ideas and concepts and meet new friends. Oh yes, I also have some new clothes.

*Great Beginnings for
Great Expectations*

2 P.M.

I was invited to attend the Plenary Session of the CDHA Councils. Sounds impressive... my first new concept **PLENARY!**

What followed was a report from the Director of each council of the CDHA, on the past year's activities and their goals and objectives for the coming year. It was clearly evident that the members of each council have worked very hard over the year on my behalf and on behalf of each member of the Association. The efforts of each council, while having a specific focus, were all aimed at increasing the visibility of the dental hygiene profession. Some of the ways in which this will be accomplished is by:

- (1) promoting our capabilities as a health profession through the development of education and practice standards,
- (2) instituting policies to govern our interaction with other health professions and related industries
- and (3) developing

and implementing services that would benefit each member. I felt my affairs were in very capable hands. These people, in the name of my professional association, were looking out for my best interests and in turn the best interests of the public. I came away from the meeting with the knowledge that the members of the CDHA councils were dedicated to the promotion and development of Dental Hygiene as a dynamic, interactive, visionary, caring profession. This group of people is very skillfully leading and managing the affairs of our Association.

7 P.M.

An Awards Dinner to honour past presidents of CDHA was held this evening. Not just any past president, but **the first** past president and several others. In all, five past presidents were each presented a gold pin signifying the Association's recognition of their efforts. As each person came forward to accept their accolades, they also shared with us their most memorable experience while in office as well as their vision for the future of dental hygiene. What wonderful stories! Stories filled with the struggles, hopes, fears, and triumphs encountered as they led the development of our profession. In some ways the changes and the challenges are still the same and yet dental hygiene has made remarkable strides toward recognition. The prevailing mood was one of pride in our collective accomplishments and a renewed vigour to face and surmount the challenges still facing us.

Friday October 15, 1993

Moving the Profession of Dental Hygiene Toward the Year 2000

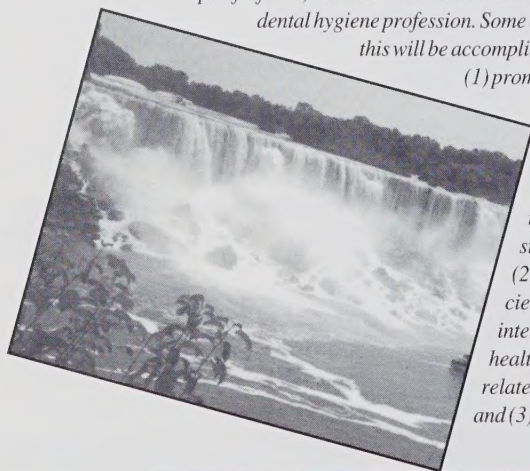
This morning I joined over a hundred dental hygiene educators from both Canada and the U.S. in a workshop to discuss the advances in the development of Dental Hygiene Accreditation Standards, Educational Standards, Practice Standards, Continuing Competence and National Dental Hygiene Certification, over the past few years. Some of the groups that have been involved in discussions and workshops to develop guidelines and standards in these areas are: the Association of Canadian Faculties of Dentistry (ACFD), the Commission on Dental Accreditation of Canada (CDAC), the CDHA's National Certification Working Group, CDHA's Task Force on Education Standards, and CDHA's Practice Standards Workshop.

I found the scope of the work accomplished by these groups to be staggering, complex and sometimes confusing.

However, the workshop facilitator and the chairpersons of each group did an excellent job in walking us through not only the chronology of the events, but the outline of their efforts to date. All of their efforts are interrelated. It was evident that all groups must now



*Dr. Roberta Bondar and
Dale Scanlan*



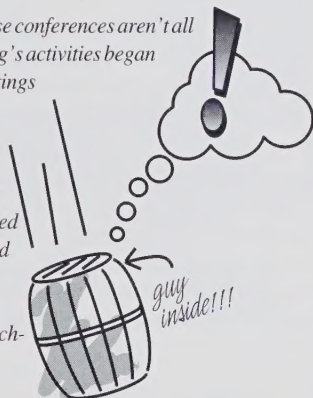
work together with a high degree of cooperation in order to achieve a credible, and viable set of standards/ guidelines that will direct Dental Hygiene Practice as an autonomous profession in the 21st century.

At this workshop, educators were given the opportunity to provide constructive solutions to the various committees as they continue with the fine-tuning of their projects. The spirit of cooperation that existed in the room was magical. One could feel the effort being put forth by all present to understand and accommodate the innovative ideas and new language being presented. A tangible bond was being created between the committee members involved in the development process and the educators whose job it would be to transmit these ideal standards to the students who will become the dental hygienists of the 21st century.

The vision statement for Dental Hygiene in the year 2005 includes: 1. self-recognition as a profession, 2. broadening our concept of practice settings and scope of practice, 3. being accountable for our practice both individually and collectively through our own regulating bodies and 4. joining in collaborative efforts with other health care agencies. The focus of this vision is to assure the delivery of quality health care to all Canadians. I found it very gratifying and uplifting to realize that Dental Hygiene practice has matured and was capable of assuming the responsibilities that go along with this maturity. It is the responsibility of each Dental Hygienist to familiarize herself/himself with this vision and to take steps to incorporate the concept into each unique practice.

Friday Evening:

Thank goodness these conferences aren't all hard work! The evening's activities began with Presidential greetings from CDHA, ODHA, ADHA, IFDH and the Chairperson of the conference organizing committee. All expressed their welcome and good wishes for a great "Exploration into the Future". Now the speeches were over, and our keynote speaker, Dr. Roberta Bondar would address us. But the conference Chair informs us that she is late or maybe lost. How could someone make it into outer space and back but not be able to find Niagara Falls? We waited in anticipation for this magnificent role model for all Canadians. She is in the hotel, but the person responsible for escorting her to the reception is so struck by awe that she forgets to stop the elevator on the 3rd floor and takes her to the top floor. Finally, she enters the reception to a standing ovation! My first impression is "She's so tiny! She does not look physically strong enough to withstand the rigors of space flight". I soon realized that she has the tenacity and the ferocity of a pit bull when it comes to realizing her dreams. I appreciated her very warm, funny and engaging manner as



she almost off-handedly spoke of the hardships of her years in preparation and training. With a slide presentation and wonderfully descriptive words, I spent an hour in space with her. She entertained and entranced me with her description of how they worked, ate, slept, flossed and performed other bodily functions while aboard the space craft. She was able to convey to me both the spiritual and physical impact space flight had on her.

She chatted with us as though she were speaking with her friends and family. Later at a wine and cheese reception some of us had occasion to personally speak with her. All evening and far into the wee hours of the morning, the happy noises of camaraderie filled the Canadiana room.



Dr. Roberta Bondar

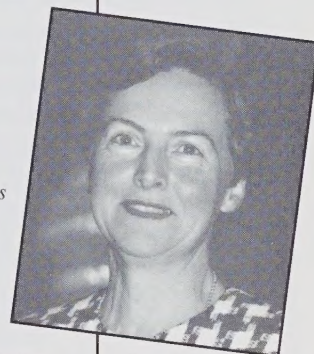
Saturday, October 16, 1993

8:00 A.M.

Breakfast with Dr. Jane Fulton. I'll never view the Canadian Health Care system in the same blind, patriotic way again! With biting sarcasm, this dynamic woman fired off a frank diatribe of Canadian politicians and their fumbling efforts to continue with our existing health care services. With a graphic display of facts, she was able to draw a distressing picture of a version of universal health care that Canadians may be forced to accept in the year 2010. By then, Dr. Fulton believes, we will have a North American Health Care System, probably administered either by the U.S. or private insurance companies. She urged us to rethink our concept of what universal health care should look like because it is inextricably bound to Canada's economic situation and program of deficit reduction. After having dinner at the White House last week, Dr. Fulton came away impressed with Hillary Clinton's Ethical Foundations of Health Reform. They are: universal access, comprehensive benefits, choice of provider, a fair distribution of costs, personal responsibility for health and intergenerational justice.

Dr. Fulton advocates four pillars for health care:

1. Efficacy of care (knowing what works)
2. Appropriateness of decisions (using what works)



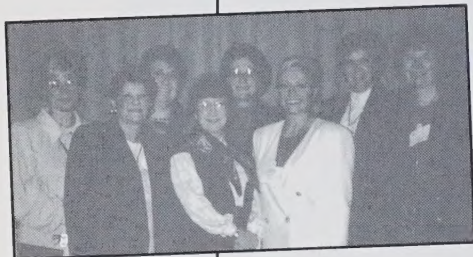
Dr. Jane Fulton



3. Execution of care (do well what works)
4. Purpose of care (clarifying the values that tell us what we wish to do).

It is the ethical principles underlying the decisions that are most important.

Dental Hygiene has a role to play in the delivery of future health care models. Dr. Fulton urged us to get involved, forming alliances with other health care agencies to forge a new, ethical system of health care delivery for Canadians. I will make every effort to hear this woman speak again.



Program Planning Committee from Canada and U.S.A.

9:30 A.M. to 4:30 P.M.

During the remainder of the day, I attended poster sessions (visual displays of current research), table clinics, free paper presentations (30 minute lecture presentations of current research) and a Theory Development Workshop. There were so many topics that it was difficult to choose which ones to attend. I wished I had the ability to be in two places at the same time, and I haven't felt that way since the time my daughters started dating! By the end of the day my head was spinning with new concepts and information. The most interesting thought came from the Theory Development Workshop. If we begin to think about ourselves as a discipline, we begin to see a relationship between science(theory) and practice. As we formalize our knowledge through scientific research the actualization of our practice becomes easier. What we know gives credibility to our practice! We all have private images of what our practice is, who the client is and what aspects of oral health care are important to teach. We need to decide on the issues and establish frames of reference and conceptual models, upon which theories are proved or disproved. Theory drives practice and practice drives theory. They are interrelated. The researchers need input from the practitioners to identify the problems encountered in practice. The problems may be clarified by research, which will close the gaps in our knowledge and improve the health of our clients both locally and world wide. Each one of us has an active role to play in the establishment of a scientific body of knowledge unique to Dental Hygiene. We are well on our way judging by the numbers of presenters here at this conference!

Saturday evening:

Time again to unwind and relax. I'm glad I decided to take advantage of the opportunity to attend the Shaw Festival at Niagara-on-the-Lake. Set in a cosy theatre in an English country garden, the play was St. Joan. I anticipated the Joan of Arc I had studied in school. Boy, was I in for a surprise! Somehow I had never pictured St. Joan in army fatigues. It was uncanny how this old story took on a decidedly modern twist. It was a powerful portrayal of good versus evil, church versus state, men versus women,

and truth versus blasphemy. The impact was too much for my tired brain.

Sunday, October 17, 1993

At breakfast we honoured recipients of the various awards and scholarships presented by CDHA and our corporate sponsors, showed our support for the CDHO's efforts toward self-regulation and thanked the hard-working members of the conference organizing committee.

Another day of presentations on another great variety of topics.

I chose to attend a session of qualitative research methodology, because I needed to hear about non-quantitative research methods. What I learned was that as a practitioner, I have unofficially been involved in qualitative research for years! I have been conducting interviews, listening to life histories, and carrying out participant observations and other such unobtrusive measurements.

All of these are qualitative research methodologies! I just haven't formally written down all my theories and conclusions yet. I have however, altered my practice based on observations that have repeated themselves over and over in different client situations. I think all of us have been involved in research with out even realizing it. Now I have some guidelines for formalizing my research. We need to do this so that we are able to share with our colleagues our results and their effect on our practice.

Sunday night:

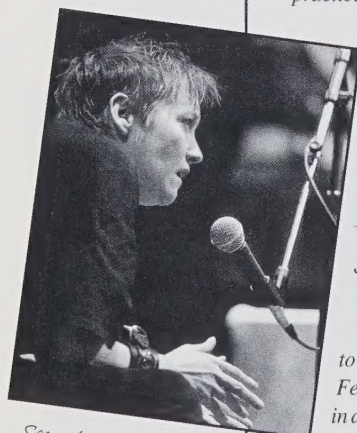
The wealth of information was overwhelming. All weekend, on the hour or half hour, hygienists moved from room to room selecting the presentations of their choice. They reminded me of a thirsty person that happened upon an oasis in the desert.

The greatest advantage of attending professional conferences is this opportunity to share my ideas with other hygienists, to validate my knowledge and to gain new insights. We owe it to ourselves and especially to our clients to keep abreast of new developments. This is an event I will take part in again, and soon. Why not June in Saskatoon? What does it take to "Sharpen your Professional Edge"?

Dianne Landry



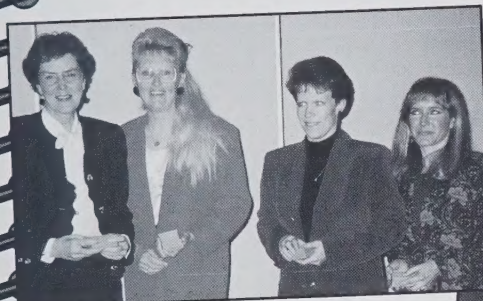
Poster Sessions



Scene from "Joan of Arc"



CDHA Practice & Regulation Council



Incoming CDHA Directors



CDHA Professional Development Council



Planning for Conference '95



USA Developers of Procter & Gamble educational series



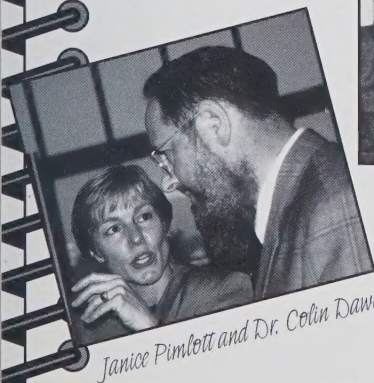
CDHA editorial staff



Local Organizing Committee



CDHA Past Presidents — from left to right — Patricia Johnson, Linda Berry, Ellen Brownstone, Sharon Amer and Mai Pohlak



Janice Pimlott and Dr. Colin Dawes

Overheard at the Research Conference:

"...Now I know why there are so many great smiles here, there's a dental hygienists' conference going on."

"...There's an atmosphere of collaboration and cooperation here today that is unparalleled to any previous experience."

"...There's a magic in this room."

"...There are so many choices, which presentation are you attending next?"

"...This conference has been energizing. I am anxious to get back home to share this with the other people in my practice and try out all these ideas."

"...I have not gone to conferences for a while because they are not really for dental hygiene; often there is one or two programs for "auxiliaries" — now I'll come back; everything here was by and for dental hygiene, it's so professional and empowering."

"...From outer space you do not see humankind, only the dramatic effects that our technology has wrought on the environment. Here is Canada, a country with the richest water resources in the world — we need to protect our environment; you can't drink oil or eat diamonds!" — *Dr. Roberta Bondar*

"...This is the first conference that I've attended where *all* of the presentations are directed towards Dental Hygiene practice."

"...This conference has given me an idea of where and how to find the answers to the questions I have about my practice."

"...Why don't hygienists view themselves as multidisciplinary?"

"...Dental Hygienists need to communicate their vision of their practice so that we can develop our unique body of scientific knowledge."

"...Your successes have not been communicated. In order for Dental Hygiene to receive the recognition that it is due; you must cut the umbilical cord to forge new alliances with other health care professions." — *Dr. Jane Fulton*

"...Innovation may be risky but the only way to coast is downhill."

"...Did you know that they can turn off the Falls at night?"

By:
Sherry L. Woite,
RDH, BEd, MEd

Qualitative Research, Education, and Dental Hygiene

Introduction

The dental hygiene profession has been strengthened by immense changes in the past decade. What new directions can dental hygiene anticipate? Taking our lead from other health professions, such as nursing, a new avenue for dental hygiene could be the use of qualitative research. As educators of dental health, whose goal is improved dental health and awareness, we can justifiably utilize qualitative research and educational ethnography to improve our teaching. Through the use of this holistic research model, dental hygiene could become more well-rounded in its overall approach.

This paper will define ethnography (as a qualitative research method), and describe the methods used in ethnographic research. It will also discuss how ethnography is used in education. How the ethnographic or qualitative methods can be used in dental hygiene practice will also be discussed. Finally, the paper will explore how clinical dental hygienists, in both community health and clinical practice settings, can use methods and insights gleaned from ethnography in their day-to-day practice as dental health educators.

What is Ethnography?

Ethnography is a qualitative (versus quantitative) research method originally designed for use in anthropology and sociology. In these two disciplines, ethnography was used to describe the lives of people, often those from other cultures. More recently, ethnography is being used to describe and understand social interactions and institutions within our own culture. Qualitative studies "aim to make meaning (understanding) of the phenomena under study"¹. Rather than extracting specific quantitative statistics, qualitative research proposes to gain a more holistic and complete understanding of what is going on by describing and then analyzing the observations.

Ethnography, as one type of qualitative research, uses two particular techniques in order to gather and evaluate data. These are participant observation and the ethnographic interview. Participant observation differs from everyday observation wherein it demands that the observer be aware of the activities around him/herself and be an objective observer of his/her own behavior. In everyday activities we do not generally do this because it would lead to 'overload'. A person's system can only process so much input from the surrounding environment. "We all adapt to the potential threat of overload by paying less attention to information we do not need or want. This blocking occurs so frequently and so continuously that we could hardly survive without it"².

Although participant observation means that the researcher must pay attention while observing, it also exists on a continuum which ranges from passive to complete participation. As a passive observer, the researcher might occupy a role in the social situation as a 'bystander', 'spectator', or 'loiterer'². At the other end of the spectrum, a complete



SHERRY L. WOITE, RDH, BEd, MEd

participant engages in the highest level of involvement. This occurs when the researcher studies a situation in which he/she is already an ordinary participant². As a researcher using participant observation, any one of the levels of participation is acceptable for gathering data, as long as all ethical (i.e. confidentiality) and researcher considerations are kept in mind and followed.

The ethnographic interview is sometimes, but not always, used in conjunction with participant observation. The ethnographic interview is used to gain verbal information or to clarify information about a particular social event through the use of an informant. Informants use *their own language or dialect* (which may simply mean non-formal, everyday speech), and are a source of information for the interviewer³. The ethnographic interview is different from a casual con-

versation. It must include the following elements: explicit purpose, ethnographic explanations (explanations which must be repeatedly offered to the informant during the interview), and ethnographic questions (either descriptive, structural, or contrast questions)³.

In both the ethnographic interview and participation observation, the data which is gathered is then analyzed in order to find any consistencies or patterns.

Ethnography and Education

Qualitative research has been successfully applied in educational institutions. Ethnography is especially useful in describing educational institutions and the interactions within these institutions. Its success lies in the fact that this method aids in describing the complex nature of these hierarchical organizations and how 'real' people function within them.

This qualitative method has been recently adapted for use in disciplines where it was not previously utilized because this method can assist in solving problems which have occurred through the use of quantitative/scientific methods. The main difficulty with quantitative research has often been the bias of the researcher, especially in the social sciences. A bias can occur in two ways, either through the choice of the research topic, or within the research itself. "At worst, (the research) results in the reification of constructs that are the projections of social biases"⁴. The most promising strategy is the use of qualitative research: "Our best shot at present is to construct research designs that push us toward becoming vigorously self-aware"⁴. This can indeed be accomplished by utilizing alternate research paradigms.

Dental Hygiene, Education, and Qualitative Research

Historically, the occupation of dental hygiene was created to teach individuals the skills necessary for the dental prophylaxis procedure and for the promotion of dental health. Much of the emphasis of dental

hygiene has, and continues to be, the education of the general public, and 'achieving health for all' in order to alleviate dental disease. This educational emphasis along with scientific advances have done much to improve the dental knowledge and general dental health of the Canadian population. A continued emphasis in this direction may well prove beneficial. But a good understanding of education, as well as alternative models of learning, are necessary. It is because we are *educators* of dental health that the qualitative research method can be used to assist our teaching by making us aware of successful models for educational initiatives.

As educators, hygienists use a variety of methods and psychological/scientific models to teach their clients. Qualitative methods can assist the educator of dental health (i.e. the dental hygienist) by focusing on clients, and their *interactions* with clients, in a more holistic manner. In fact, "the purpose of applied research and evaluation is to inform action, enhance decision making, and apply knowledge to solve human and societal problems. . . applied evaluative research is judged by its usefulness in making human actions and interventions more effective and by its practical utility to decision makers, policy makers and others who have a stake in efforts to improve the world"⁵. Ethnography itself, has the ability to incorporate many strategies which are useful in client-education. Ethnography is able to elicit phenomenological data (the world view of the participants); provide research strategies which are empirical and naturalistic; is holistic (gives the total phenomena); and is multimodal and eclectic (in that a variety of research techniques are used)⁶. Because of these characteristics, the ethnographic method can be used in any teaching situation, including dental hygiene.

Qualitative research and ethnography may be successfully used at the level of client-hygienist interaction. When ethnography is applied on a one-to-one level of interaction, ethnography is often not thought of or considered to be research. Essentially, qualitative research points to the need for practitioners to be more disciplined and thorough in gathering information in their own settings. "All educators can be more effective by employing qualitative research in their work"⁷.

This concept may be directly applied to the educator of dental health working in the private practice environment. If the dental educator loses this awareness, then the client may be seen to be just another mouth coming through the operatory door rather than an individual with a lifestyle that affects his/her dental health. An example of this type of information which would improve the educator's awareness, is knowing whether or not a client has been under a significant amount of stress since the last appointment.

The qualitative approach allows for change;

The belief that practitioners can improve their effectiveness by employing the qualitative perspective is rooted in the way the qualitative approach views change. . . the usefulness of the qualitative perspective to practitioners is related to seeing all people as having the potential to change themselves and their immediate environment, as well as becoming change agents in organizations in which they work. Qualitative research skills can play a part in helping people to live in a world more compatible with their hopes by providing tangible information on what it is like now.⁷

This is important for both the clinical and community health dental hygienist where the settings are full of change. This change can occur either on a day-to-day basis when schedules can be thrown off by one patient alone, or on a larger scale where new sterilization techniques have completely altered today's dental office routines. The ability to deal easily with change then, is a must!

One might question how exactly a dental hygienist would *specifically* use qualitative perspectives as a dental educator. As part of their role, dental hygienists can act like researchers. Although they will not necessarily conduct in-depth interviews or keep detailed field notes as would be done by an anthropologist, they can be more systematic in their note-taking. They can "turn the conversations they might normally have into more productive information-gathering sessions. Incorporating the qualitative perspective means nothing more than being self-conscious, actively thinking and acting in ways that a qualitative researcher does"⁷. For example, a colleague of mine (a university professor) related to me that she felt as though she were being treated as a child at her last hygiene appointment. Perhaps if the hygienist had done a little more information-gathering and had in turn effectively applied that information, the dental appointment would have developed more positive and productive rapport.

It can be seen that the dental client and dental hygienist can derive some significant benefits from the application of the qualitative perspective. One benefit the practicing hygienist might gain from this approach, is the ability to mentally step back from his/her practice, distance themselves from immediate conflicts, and gain a broader view of what is happening⁷. The resulting insight could enable them to be a more effective dental health educator.

Conclusion

The use of the qualitative method from the social sciences, can provide much needed background information necessary to create new and better working and teaching models. Qualitative research works well as an addition to the already well-understood qualitative method. By adding qualitative or ethnographic research, a more complete picture could be achieved. This model of research can be applied very successfully to the social sciences, including education and dental health education.

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Sherry Woite completed her Diploma in Dental Hygiene at the University of Alberta in 1980. She worked as a Public Health Dental Hygienist until 1987, before returning to the University of Alberta where she completed her Bachelor of Education (1990). She completed her Master of Education in August 1993 at the University of Alberta and is currently instructing at Grant MacEwan Community College in Edmonton.

By:
Jackie Smorang, BA, RDH, MSED
 and
Janet Erikson, SDT, RDH, BED

An Extended Care Facility Mouthcare Project — CFDE Report

A. Introduction

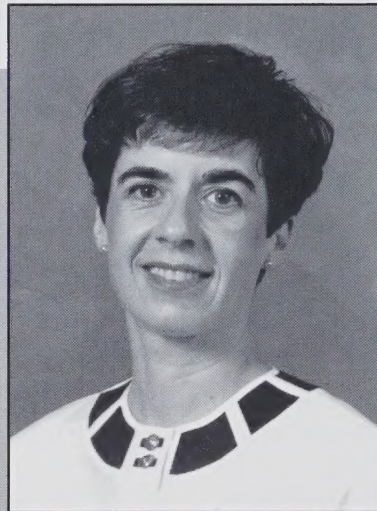
The poor oral health status of residents residing in extended care facilities has been well documented in the research. As greater numbers of residents retain their natural teeth into their senior years, and their ability to perform adequate daily self-care declines, oral health problems become more evident.

Being edentulous or having an unsightly dental appearance is no longer a socially acceptable part of aging. Not only does an attractive smile contribute to social acceptability, it has a positive impact on self-image and increases confidence in social situations. Eliminating mouth odor has similar advantages. Marinelli (1983) reported that "handicapped elderly with mouth odor, in residential settings, are unlikely to receive anything more than essential care from caregivers on whom they are reliant".

Preventive dentistry is the backbone of dental care for residents in extended care facilities. The maintenance of self-care is paramount in preventing rapid deterioration in oral health. Where self-care is inadequate because of deteriorating manual dexterity and/or mental abilities, the role of caregivers cannot be overstated.

The most recent Calgary dental survey of chronically ill institutionalized residents was conducted in 1980 by Calgary Local Board of Health. The results stated that "all ages had high unmet dental needs". One of the recommendations from the survey was the need for mouthcare inservices for caregivers in all extended care facilities. Unfortunately over the last ten years there were no preventive dental education programs implemented in their facilities.

Historically, staff of extended care facilities are not well trained in the provision of mouthcare for residents with varying levels of physi-



JACKIE SMORANG, BA, RDH, MSED



JANET ERICKSON, SDT, RDH, BED

cal and mental impairment. A mouthcare knowledge and attitudes survey of extended care nursing staff (September 1992*) reported that many misconceptions still exist about dental disease and prevention, and specifically, what constitutes appropriate oral care for their residents. A mouthcare inservice* was developed to address these misconceptions. The inservice was presented to over 240 caregivers in one extended care facility. The subjective inservice evaluations were all very positive.

To decide if mouthcare inservices should be presented in other extended care facilities, the following study** was conducted to determine the effectiveness of the inservice in changing mouthcare knowledge and attitudes of the caregivers.

B. Objectives

1. To determine if a mouthcare inservice, involving a slide presentation, role-playing and hands-on demonstrations, is an effective method to convey dental health information to caregivers.
2. To determine if a mouthcare inservice results in a change in mouthcare knowledge and attitudes of the caregivers.

C. Sample

The population studied were extended care nursing staff working in a facility with over 300 mentally and physically handicapped residents. Only the staff who attended one of the January 1993 inservices were included in the sample.

D. Method

The Mouthcare Questionnaire which was distributed in September 1992 provided the baseline data for this survey.

The instrument used for this survey was the Mouthcare Questionnaire — Phase 2. This questionnaire included 6 items of

* Funded by a Warner-Lambert/CFDE fellowship 1992 and Foothills Hospital Calgary, Alberta

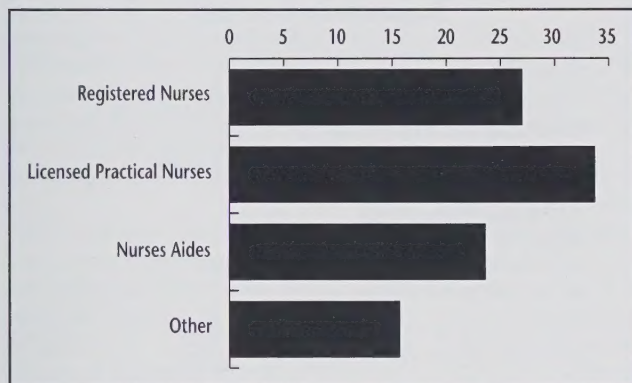
** Funded by a Warner-Lambert/CFDE fellowship 1993

demographic information; 7 questions related to attitudes and current practices regarding oral care; and 25 true/false statements concerning oral problems and mouthcare techniques.

On May 1, 1993, questionnaires were distributed to 188 staff who attended one of the mouthcare inservices. Names were obtained from the inservice sign-in sheets. Participation in this survey was voluntary. Staff were asked not to sign the questionnaire. There was no identification numbers on the questionnaire and therefore, there was only one distribution.

E. Results

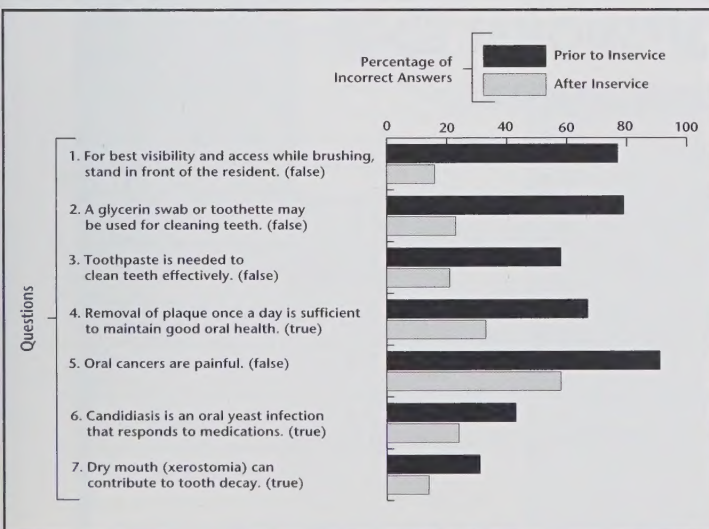
The overall response rate was 48%. The various staff positions responded as follows:



1. Knowledge Level

There were twenty-five (25) true and false questions to determine knowledge of oral problems and mouthcare techniques utilized by the staff. These questions were identical in both questionnaires. Prior to the inservice, the average correct score for all respondents was 62% and three months after the inservice, the average correct score increased to 80%.

The incorrect responses to the true and false statements in the questionnaires were compared. There was a significant reduction ($p<0.01$) in the incorrect responses to the following statements in the questionnaire—phase 2:



The knowledge level regarding the specific topic of mouthcare techniques improved significantly ($p<0.01$). This may be attributed to the reinforcement of this information in the role-playing demonstration which followed the slide presentations and also during the hands-on demonstrations on the nursing units.

2. Attitudes

In the second section of the questionnaire, several questions were designed to determine the respondents' attitudes regarding mouthcare. Respondents were asked to state "how comfortable they felt they were with their level of mouthcare knowledge prior to the inservice (figure 1) and after the inservice (figure 2)". The respondents indicated there was an increase in their comfort level regarding mouthcare knowledge after the inservice.

Respondents were asked if the "techniques taught in the inservice made it easier for them to provide mouthcare for their residents". The responses were as follows: yes 80%, no 2%, don't know 18%.

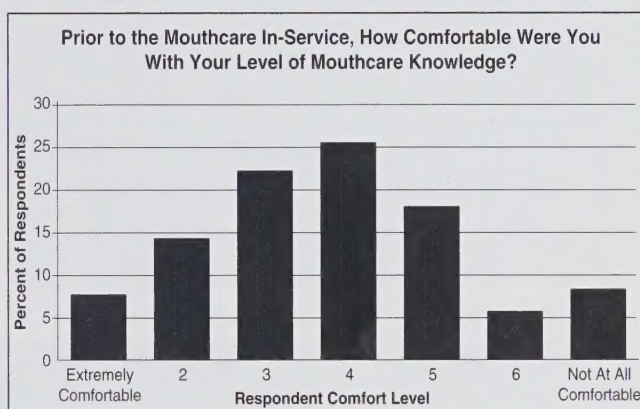


Figure 1

When the respondents were asked if they felt "the level of mouthcare provided to their residents had improved since the inservice", the responses were as follows: yes 75%, no 4%, don't know 21%.

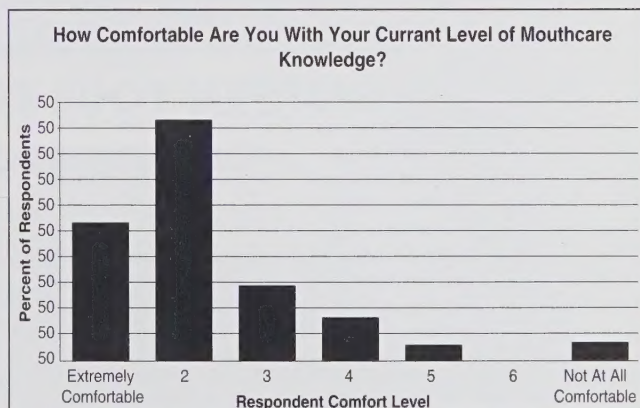


Figure 2

Results indicated that a mouthcare inservice, involving slides, role-playing and hands-on demonstrations, increased mouthcare knowledge and changed mouthcare attitudes of extended care nursing staff.

"Results indicated that a mouthcare inservice... increased mouthcare knowledge and changed mouthcare attitudes of extended care nursing staff."

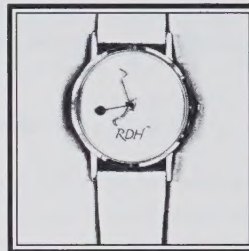
F. Conclusions

Findings of this study suggest the need to include comprehensive mouthcare inservices in the basic training and continuing education programs for extended care nursing staff. This would enable the nursing staff to provide appropriate mouthcare for their residents thus enhancing their quality of life.

Jackie Smorang and Janet Erikson are co-recipients of the CFDE/Warner-Lambert Canada fellowship for 1992 and 1993. This article is a report outlining their Mouthcare Project which was submitted to CFDE. Ms. Smorang is a 1975 graduate of the School of Dental Hygiene, U. of Manitoba and works fulltime with the Division of Oral Medicine, Foothills Hospital, Calgary. Ms. Erikson is a 1988 graduate of the Dental Hygiene Program, SIAST, Regina, Saskatchewan.

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Authors should submit one copy of Appendix A by February 15, 1994.

Initiating a Smoking Intervention Program

By: **Beverley Kassirer, RDH** and **Anne Lessio, BSc**

Excerpted from Ontario Dentist, October 1993

Current trends in health care indicate that tobacco use is incompatible with the health continuum. This is well documented and undoubtedly, few tobacco users remain unaware of the health risks. What may be less clear is whether the client's knowledge of risk extends to include the oral cavity.

The article, "Initiating a Smoking Intervention Program", outlines the numerous detrimental effects to the general physiology and specifically to the oral cavity, caused by the use of tobacco. Examples include an increased opportunity for: periodontal bone loss, Acute Necrotizing Ulcerative Gingivitis (ANUG), leukoplakia, oral cancer, and impaired healing.

Possibly less well known is the induced vascular response resulting in a hampered healing process. The authors state that both antibody availability and leukocyte chemotaxis to the tissues of the periodontium are weakened. Gingival bleeding among those who smoke is reduced, leading the clinician to observe that gingival redness, the presence of exudate, etc., are not as clinically evident even when the client has the same amount of plaque deposit on their teeth as a non-smoker. The article quotes Ismail, et. al. (1983) and Locker (1992): "Smoking directly influences the periodontal condition irrespective of oral hygiene behavior, age, race, gender, socioeconomic status, or dental visiting patterns". The article continues to highlight other dental and physical health risks including: relationships of tobacco use to tooth loss; caries; DMFS (Decayed, Missing, Filling Surfaces); and cerebrovascular, cardiovascular and gastrointestinal conditions.

The implication is that dental hygienists will likely treat clients suffering from periodontal conditions directly exacerbated by tobacco use at some point in their professional careers. Members of the dental profession, when questioned, indicated that hesitancy in promoting tobacco cessation programs

stemmed from the fear of estrangement from their clients. Time constraints, insufficient knowledge of how to implement counseling techniques and/or uncertainty about effectiveness also contributed to skepticism.

Statistical support for smoking cessation stated that 9-17% of clients exposed to a program, quit. This compared favorably with those clients quitting unsolicited, at 2-3%.

The philosophy of the program is based on three "A's". Clients are "Asked" about their patterns of tobacco use while they are undergoing an examination. If client interest in quitting is elicited, then they are "Advised" to quit. Personal and social benefits are also stressed. "Assistance" is provided in the form of resource material and positive reinforcement. Information about the nicotine patch/gum is made available to the client, and physician referral is considered if warranted. Studies indicate it may take "five or more attempts" prior to successful cessation. The dental professional's support is essential to underscoring the belief that the client can be successful.

With healthcare providers from all disciplines supporting subsidence of tobacco use, failing to intervene as a member of a profession embracing health promotion may raise an ethical issue, in the eyes of the authors. With that in mind, the article reinforces that: a program can be easily integrated into most dental practices, it's worth the effort, and it works.

Carol Barr Overholt graduated from the University of Pennsylvania, School of Dental Medicine, Department of Dental Hygiene in 1982. She has practiced clinically in Orthodontics, Periodontics, and General Practice. Currently, she is a full-time faculty member at Niagara College in Welland, Ontario in the Dental Hygiene program and is also completing a Bachelor of Education at Brock University. Carol has contributed abstracts, book reviews and self-tests to *Probe*; in future, she will be contributing an abstract of current research as a regular feature of *Probe*.

Reviewed by:
Carol Barr Overholt, RDH

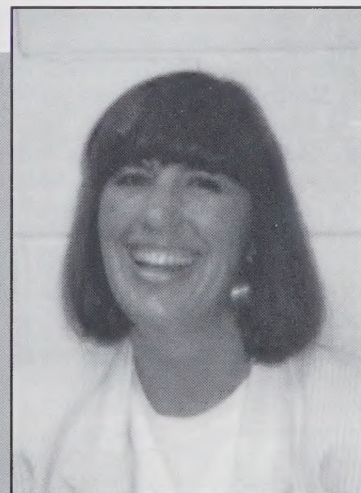
• NEWSBRIEF •

Nicotine patch is effective, study says

A significant — 25 percent — quit rate is reported for patients in a one-year study of the nicotine patch's efficacy, with physician counseling, in aiding smoking cessation, reports the Center for Pulmonary Disease Prevention.

One year sustained non-smoking rates were nearly three times higher (25 percent vs. 9 percent) for patients using the patch than those wearing a placebo or dummy patch, reports the Palo Alto, California, institute.

The study was designed as a model for the stop-smoking therapy that a primary care physician could provide patients in a private office practice. No special psychological or behavioral skills or services were used, the Center reports. The study's results were published in the August edition of *Archives of Internal Medicine*, the American Medical Association's specialty journal for internists and other primary care physicians.



CAROL BARR OVERHOLT, RDH

Major League Shutout...

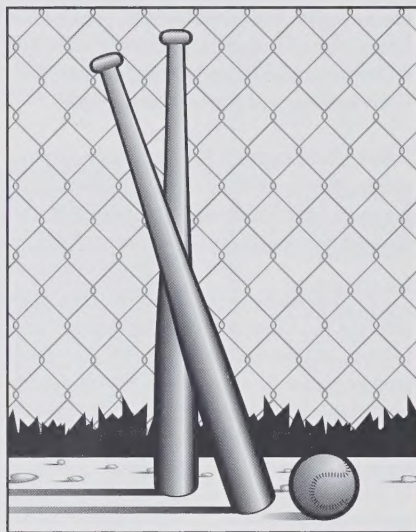
How Do You Communicate with Your "Pedo" Client?

By:
Marlene Mizzau
University of Manitoba

"Pedo". For me, this term conjures up images of inquisitive and naive youngsters who are appropriately in awe of the professional who will be caring for them. I can also visualize a group of enthusiastic but cooperative children who will benefit greatly from the services I will render, and who will be fully appreciative. (In other words, I can see everything but the halo!) Mutual respect is a key element in the relationship I might find myself having to establish with them. Such was not the case, however, with the child I was "blessed" with during one memorable clinic appointment.

My first impressions of this client seemed to confirm my expectations. Tom (the name has been changed to protect whatever amount of innocence may be left) was an 8 year-old boy. He appeared very quiet and compliant as he walked in with his father. I even detected a slight smile on his face as I introduced myself. While we made our way to the assigned unit, I purposely conversed with him, as well as his father, to help satisfy his need for inclusion in the process. At the unit, I attended to him by establishing eye contact and facing him squarely as we explored his past dental experiences and what feelings he had toward his oral health. While his father was present, the child seemed responsive to my attempts to initiate a relationship. Unfortunately, the rest of the appointment did not continue along the same vein! I became suspicious when his father appeared overly happy to leave his son in my charge. Did he know something that I didn't?

After the medical history had been checked, the father left. Almost immediately after his father's departure from the operator, this child discovered the air/water syringe and its ability to shoot a jet stream of water clear across the unit to drench the opposite wall. "What's this for?" he queried innocently. "Well", I explained, "I haven't used it for cleaning the walls yet. I use it more for rinsing things out of people's mouths." He then closed his lips around it and proceeded to drink from it. *Jonah (my son) would NEVER behave this way at HIS dental appointment.* In comparing Tom's behavior to Jonah's behavior, I had made the mistake of evaluating its worth; judging its acceptability, or more appropriately, its



unacceptability. If my thoughts had been verbalized, this would not have been helpful feedback, but no doubt I must have given him some nonverbal cues as to my annoyance. Even at this young age, I feel they must have some capacity to sense these nuances. I distracted his attention from the air/water syringe by giving him my large model of teeth to play with. I told him that there were two teeth which were removable and challenged him to figure out which two they were. This kept his hands busy for a short time while I got some things done. "That was easy! What can I do now?", he asked eagerly.

Before I continue relating the events of that appointment, it would be helpful to shed some light on our respective environments. He is a young, inexperienced male whose attitude towards dental health seems indifferent. I am a more mature, experienced female who is very much focused on achieving good dental health for all. Overlap in these environments which might have contributed to more effective communication was limited to familiarity acquired in his social role as a son, and familiarity acquired in my social role as a mother. This overlap proved to be inadequate.

Psychological noise also existed which impaired my ability to communicate accurately. It stemmed from the fact that I was under

stress to finish this client in one appointment. Self-assessment of my own abilities as a dental hygiene student had revealed that speed was not my strong point. Being fully aware of this fact compounded the stress I brought with me that day. Another source of psychological noise was the existence of preconceived notions which were based on three things: (1) the visual imagery with which I entertained myself (described in the introduction), (2) my own experiences I've had dealing with my children, and (3) overconfidence in my ability to handle the situation (irrespective of the time element).

I acknowledge that it was unfair of me to buy into the preconceived notions of what my first pedo client would be like; conscious effort should have been made to resist the temptation to do so. Thus, having not been successful in keeping an open mind, I was already placing the success of the interaction in jeopardy by bring in my personal biases. This prevented me from dealing with him as an individual and the accuracy of the encoding and decoding in our interaction was bound to be affected. "So how 'bout those Jets!", I said, feigning enthusiasm about professional sports. I incorrectly assumed that he enjoyed hockey as did Jonah. "I don't like hockey", he muttered disinterestedly. Strike one!

Professional communication lies somewhere in between interpersonal and impersonal communication. It can be detrimental if the nature of the communication becomes too interpersonal in a clinic situation. Therefore, as rewarding as it may be personally, it is counterproductive and the possibility of it progressing to unethical levels exists. There should be enough interpersonal communication to show that we care but also enough impersonal communication to maintain a good professional distance. With this in mind, I must avoid the problem of putting too much effort (and time) towards establishing the client as a person and not just a "piece of meat" from which I must learn, while at the same time attempting to put the client at ease. Although it never took on the traits of uniqueness, irreplaceability, and scarcity of a true interpersonal relationship, I felt that it may be contributing to debilitating feelings — given my status as a first year dental

hygiene student. The fear I have of harming my client may increase as the client becomes more of a "person" to me, and this would work against my progress in clinic. Thus, getting back to the case at hand, I was not completely upset that I was not having much success at relating to Tom interpersonally. After all, I was there not as a counselor, but as a dental hygiene student. Although I fully intended to maintain decision control in the interaction, I was receptive to the possibility of Tom assuming conversational control. This he did quite nicely. As it turned out, he was quite a little chatterbox, possessing the unique talent of being able to talk with a mirror and tongue depressor in his mouth.

As I proceeded with the appointment requirements, Tom made it clear to me that he would have preferred to be elsewhere. In itself, this is not unusual, even when dealing with adults. However, Tom had the three "im's" most often associated with youth — impatience, impertinence, and impetuousness. He asked incessantly, "Are we finished yet?" In response, I reminded him that we would be finished much sooner if he would sit still. But this was apparently asking quite a bit of Tom. His chart had mentioned that he was "hyperactive". I, of course, had often used the term loosely in describing Jonah's behavior at times, but I know now that Jonah is NOT hyperactive. Tom is.

I was beginning to experience some debilitating feelings. I then initiated self-talk in an attempt to dispute some irrational beliefs I had. I realized that several fallacies were contributing to my debilitating emotions: the fallacy of perfection (it is not acceptable for me to make mistakes); the fallacy of shoulds (I am a mother; I should be able to manage this child through his appointment); and the fallacy of catastrophic expectations (I'm never going to finish this patient in one appointment!) Through self-talk and self-monitoring I was able to maintain my composure and continue on.

I was amazed at how much more energy he seemed to acquire since the departure of his father. While I was working on his teeth, he would kick his legs up into the air and even tried several times to reach my instrument tray with his feet. I explained to him that I used these instruments to work inside his mouth. If he touched my instruments with his feet then the bugs that were on his feet would jump onto the instruments and then I wouldn't be able to put them into his mouth. I immediately regretted providing him with this incentive (for this was exactly what he wanted — to have the treatment stopped). I then placed the bracket table further out of reach.

The light was a definite problem throughout the entire appointment. He was content at first to wear the sunglasses I had provided for him, but while I was removing some plaque and calculus from his teeth, he suddenly refused to wear them and demanded that I turn the light off immediately. I empathized with his feelings of irritation at the brightness of the light and mentioned that sometimes they really bothered me too. In trying to take an assertive approach to this conflict management, I told him that I would turn the light further away from his eyes but I would have to keep it on because it helped me see everything inside his mouth. In increasing his awareness as to the benefits of the light, I said that wearing the sunglasses was a good idea because they helped to protect his eyes; besides which, he looked "cool" in them. He acquiesced, but only for a short time. Later, he tried to kick the light away with his feet. When he did not succeed with that approach, he jumped up on the chair and moved the light away with his hands. "Hey, I can see everything from up here!", he shouted gleefully. In brainstorming possible solutions and outcomes (although some might say it more closely resembled an ultimatum), I reminded him of his father's parting remark to me to inform him of any misbehavior during the appointment. "I sure would hate to have to tell your father that you've been swinging from the lights today. I don't think he'd like that very much." As much as I regretted threatening him with this, the irreversibility of communication prevented me from taking it back. But he did sit back down after I said this.

Perhaps the conflict that occurred throughout the appointment was based on his need to feel safe in the midst of strangers and unfamiliar surroundings. This is one of the most basic needs identified by Maslow, and based on his theory, it is important to satisfy this need before addressing the other needs in the hierarchy, i.e., social needs, self-esteem needs, and self-actualization needs. His unmet need for safety may have been due to my lack of ability to inspire him with confidence in my abilities or earn his respect and trust.

When we finally reached the end of the appointment, I said that I had something in my kit that I thought he might like to take home with him and I pulled out a roll of dinosaur stickers. "I don't like stickers." Strike two!

We met his father in the waiting room.. His father greeted us and asked how the appointment went. I said that he had quite a son and that the appointment went just fine. After going into more detail about the dental hygiene treatment and education, I turned to Tom and said, "Well, it was a real pleasure meeting you Tom.

Will you come back and visit us again sometime?" Silence. Strike three!

I felt dejected and demoralized as I left the batter's box and headed back to the dugout. What did I do wrong? Knowing what I know now, would I do anything different next time? All I can do is try to raise my spirits by keeping in mind that this awkward stage of communication competence will progress eventually to skillfulness and then further to integration in all my daily interactions, as long as I put into practice all that I've learned. Grand slam homeruns are few and far between but I'll take the occasional single and double when I can get them.

Marlene Mizzau is a second year Dental Hygiene student at the University of Manitoba. This paper was written as an assignment for a first year communications course. Marlene originates from the small northern mining community of Timmins, Ontario and is the mother of three young children. She assures us that she has since had more pleasant clinical experiences and is looking forward to practicing as a Dental Hygienist after graduation.

• NEWSBRIEF •

NIDR study looks at dental composites

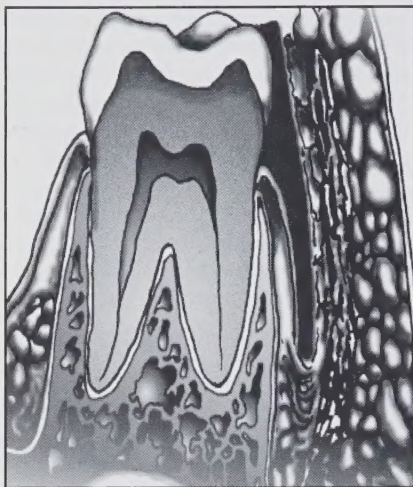
Long-term wear resistance of dental composites is the subject of a five-year study funded by the National Institute of Dental Research.

In a study of 45 patients, researchers are looking at the degree of polymerization or cure that takes place with varying amounts of exposure to blue light in the hardening process, reports researcher Jack Ferracane, PhD, of the Oregon Health Sciences University School of Dentistry.

He says the study is in its second year and that so far, things are going according to their predictions. "Increasing the amount of polymerization seems to increase the wear resistance," he writes in *Caementum*, OHSU alumni newsletter.

"The NIH (National Institute of Health) is pushing for replacement materials for amalgam, actively requesting research into alternative materials," he notes. "Composites are the likely candidate, but there are still a couple of problems."

In addition to the wear resistance, he writes, there is the problem of shrinkage as the composites cure, affecting the seal with the tooth. "I think an esthetic material that will completely replace amalgam is still five to 10 years away," he said.



1. If the contour of the buccal or lingual crest of curvature of a tooth is excessive, it is likely the gingival tissue in that area will be:
 1. overstimulated
 2. understimulated
 3. overprotected
 4. underprotected

A. 1,3
B. 1,4
C. 2,3
D. 2,4
2. An adult patient enters the dental office with 10 permanent anterior teeth present instead of 12. There is no history of trauma or extraction. The teeth most likely to be missing are the:

A. maxillary central incisor
B. maxillary lateral incisor
C. maxillary canine
D. mandibular central incisor
E. mandibular lateral incisor
3. Fractured maxillary anterior teeth most often occur in children with a:

A. Class II, division I malocclusion
B. Class II, division II malocclusion
C. Class III malocclusion
D. Class I malocclusion
4. The mesial and distal developmental depressions found on the roots of many teeth:
 1. provide spillways for food during mastication
 2. help to anchor the tooth in the alveolar bone
 3. help to prevent rotation of the tooth

A. 1 only
B. 2,3
C. 3 only
D. 1,2,3
E. 1,3

Dental Anatomy

5. Upon examination, a hygienist finds furcation involvement on a premolar tooth. The furcal involvement found would most likely be on a:

A. maxillary first premolar, buccal surface
B. maxillary second premolar, proximal surface
C. maxillary first premolar, proximal surface
D. mandibular second premolar, lingual surface
E. maxillary second premolar, buccal surface
6. Which of the following conditions is not found in a Class III malocclusion?

A. the maxillary incisors are protruded
B. the mandibular incisors are crowded, but are lingual to the maxillary incisors
C. the maxillary and mandibular incisors are in edge to edge occlusion
D. the maxillary incisors are lingual to the mandibular incisors
E. the anterior teeth are in crossbite
7. Why would furcation involvement with loss of the PDL be more difficult to treat on a maxillary 1st premolar than a mandibular 2nd premolar?

A. vertical longitudinal depressions coronal to the furcation
B. close proximity to the adjacent teeth
C. axial inclination
D. A and B
E. A, B, C
8. The feature(s) which determine the resistance of a tooth to occlusal and other forces are:

A. furcations
B. root concavities
C. vertical depressions on root surfaces
D. root curvatures
E. all of the above
9. Canines are good anchor teeth (abutments) for a fixed bridge or a partial denture because of their:

A. thick buccal to lingual dimension
B. length and size of the root
C. position in the arch
D. canine eminence
E. all of the above

10. Which of the following terms are related to the general arrangement of the arches and the inclinations of individual teeth to allow the most efficient use of the forces of mastication?

A. Curve of Spee
B. Arc De Triomphe
C. Curve of Wilson
D. A and C
E. all of the above

Answer Key:
6.A 7.D 8.E 9.E 10.D
1.C 2.B 3.A 4.B 5.C

Submitted by Signe Jewett and Daphne Cringan
University of Manitoba School of Dental Hygiene

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Restorative Dental Services and Manitoba Dental Hygienists

By:
Christy Cessford, RDH
and
Natasha Kravtsov, BA, RDH

Abstract

The purpose of this paper was to discover the attitudes and level of restorative dental services provided by dental hygienists in Manitoba. Part one included six confidential interviews; three with dentists who had dental hygienists providing restorative dental services in their offices on some basis, and three with dentists who had dental hygienists practising in their traditional periodontal roles only. The second part was a survey designed to determine how many dental hygienists provide restorative dental services and what are their attitudes towards these services. Also investigated was the attitude of those dental hygienists who do not provide these services. Surveys were mailed to two hundred randomly selected, licensed, Manitoba dental hygienists, including a survey for their employing dentists.

Confidential interviews were structured from the formatted survey which had yet to be distributed to the participants. The dental hygiene surveys were statistically analyzed for demographics and types of restorative dental services provided. Open-ended questions in the survey were categorized and tabulated. There was a fifty percent completed survey response rate from dental hygienists. Fifty-two dentists completed the survey. Thirty-nine percent of the surveyed dental hygienists never provide restorative dental services, while ten percent provide restorative dental services on a daily basis. From the dentists surveyed fifty-six percent of respondents had at some point worked in a practice where a dental hygienist provided restorative dental services.

In conclusion, the authors determined that there is greater utilization of restorative services provided by dental hygienists than perceived. Also, most dental hygienists felt that their knowledge of dental materials and restorative skills enhanced their overall client care.

Introduction

This survey was compiled as part of a project in a second year Dental Hygiene course at the University of Manitoba School of Dental Hygiene during the 1992-1993 academic year. The purpose of the survey was to determine the level of restorative dental services provided by dental hygienists in Manitoba, and at the same time to document the attitudes of both dental hygienists and dentists toward the provision of these services by dental hygienists.

The provision of restorative dental services by dental hygienists has been practised in Manitoba since 1972 (1). All graduates of the

University of Manitoba, School of Dental Hygiene must successfully complete the restorative portion of the curriculum. This is similar to the structure of the programs at Dalhousie University and in Quebec.

Methodology

The study was divided into two parts. The first part was a survey that was sent to two hundred Manitoba Dental Hygienists, and accompanying it was a survey for an employing dentist. The second part consisted of in-person interviews with six Winnipeg dentists. The dentists were divided into two groups: Group A delegated restorative services to dental hygienists, and Group B did not.

The survey for the dental hygienist consisted of sixteen questions. The questions were designed to establish a demographic portrait of dental hygienists who provide restorative dental care and those who do not, as well as to uncover their beliefs and attitudes regarding dental hygienists providing such services. Some questions were structured, and some were open-ended. The data was tabulated manually. The responses which most frequently appeared for the open-ended questions became the response categories for these questions.

The Manitoba Dental Association provided a list of all dental hygienists licensed in Manitoba. A total of two hundred surveys were sent out to licensed Manitoba Dental Hygienists. This number represents slightly over one half of all licensed dental hygienists in the province. All dental hygienists residing outside Winnipeg city limits were surveyed, while Winnipeg dental hygienists were surveyed by random selection. One hundred and twenty-one surveys were sent to dental hygienists in the City of Winnipeg, and seventy-nine surveys were distributed to rural and city of Brandon dental hygienists. The dental hygienist participants were instructed to give the accompanying dentist survey to a dentist in the office where the dental hygienist was employed.

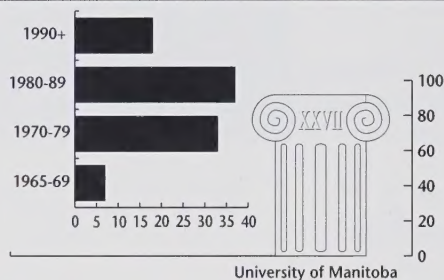
The interviews were conducted at the dentists' offices, except for one which was done over the telephone. The dentists were asked questions identical to those on the dentist survey. These interviews allowed a more in-depth investigation of the reasons dentists delegate restorative dental services to dental hygienists. The identity of all participants remained confidential throughout the survey. The interviewed dentists were given a group designation to ensure their confidentiality.

Results of the Dental Hygienists' Survey

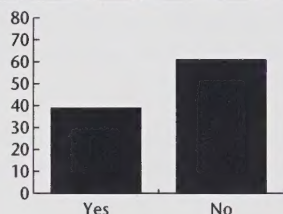
Ninety-five completed surveys were received by the return date. All of these surveys were used for data analysis. Thirteen surveys were returned unopened due to an address change. These were not included for response rate data. The response rate for dental hygienists was fifty percent. (no response percentages not included)

A. Demographic Data (Hygienists)

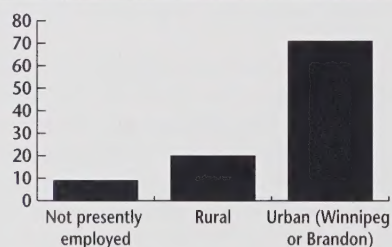
When and where did you graduate?



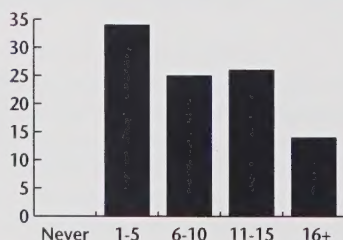
Do you hold other certificates, diplomas, or degrees?



Practice location



Years of Dental Hygiene Practice



Results of the Dentists' Survey

The number of surveys returned by dentists was fifty-two. This gives a response rate of twenty-eight percent. (no response percentages not included)

Interview Results

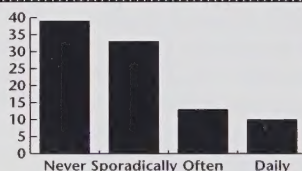
Six Winnipeg dentists were interviewed. They were asked the same questions as the dentists on the anonymous surveys. However, the interview format allowed for a more open approach to gain further qualitative information. Dentists were divided into two groups. Group A have dental hygienists providing restorative dental services, and Group B choose to do all restorative procedures themselves.

Much of the information obtained closely parallels the results of the surveys. Interview data reflected the need for dental hygienists to be informed on new restorative dental procedures and dental materials that appear on the market. The identified reasons by Group A for not having a dental hygienist provide restorative services were that the dentists believed that they could do the job in half the time, and that they preferred to complete all work for which they were ultimately responsible.

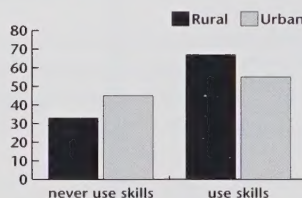
The dentists from group B agreed that knowledge of restorative dentistry helps a dental hygienist to provide more comprehensive care for patients, but that providing restorative services is expanded and not integral to dental hygiene practice.

B. Utilization of Restorative Dental Skills

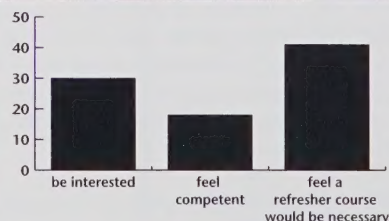
Use of Restorative Skills



Percentage of Rural vs. Urban Dental Hygienists Providing Restorative Dental Services



Dental Hygienists Interest in Providing Restorative Dental Services If Opportunity is Presented (multiple responses)



C. Specific Restorative Dental Services Provided

Services:	Never	Sporadically (%)	Often	Daily
rubber dam placement	41	34	13	11
matrix & wedge placement	51	22	11	15
liners/bases placement	43	22	12	15
condensing amalgam	42	29	12	15
carving amalgam	36	27	12	15
composite resin placement	56	21	11	12
composites finished & polished	50	23	12	10
preventive resin restorations	50	24	11	9
temporary restoration placement	40	36	16	6

Discussion of Survey Results

When considering the proportion of restorative services provided by the dental hygienist strictly on a daily basis, the utilization rate is low (10%). However, when all the categories of utilization are considered, (refer to section B) the rate of utilization is over fifty percent when categories are combined.

Initially, it was expected that the data would reveal that more rural dental hygienists use their restorative skills. A Chi-Square analysis of

the data showed that there is no statistical significance between the two groups. Fifty-five percent of urban dental hygienists provide restorative services, while rurally sixty-seven percent of dental hygienists provide these services.

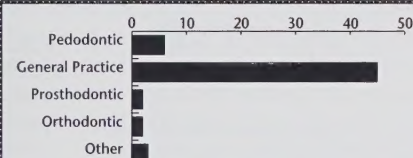
The dentists' response rate was affected by two primary factors: (1) filling out a survey for only one of several dental hygienists employed in their office, and (2) employment of dental hygienist at the time of the survey would affect the distribution of the dentist survey.

Originally, it was assumed that most dentists would not be interested in delegating restorative procedures to a dental hygienist. The responses and comments given in the survey, and the interviews, by those who were interested revealed a positive attitude toward delegating restorative procedures.

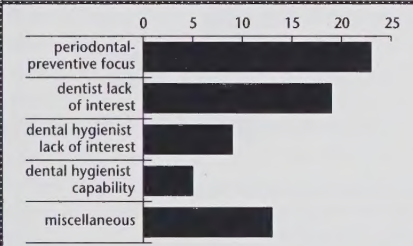
When the responses of the dentists and the dental hygienists are compared, some interesting results are apparent. For example, the dental hygienists felt restorative dentistry is an expanded component of practice but is an integral part of preventive service. The dentists felt that it is an expanded part of practice because of a perceived low utilization rate. In regard to reasons for the non-delegation of restorative services to dental hygienists, the dentists felt it was not economically feasible and that the number of patients requiring restorations is decreasing. Dental hygienists stated that non-delegation is due to the preventive focus in the dental office.

D. Dental Practice Comparison

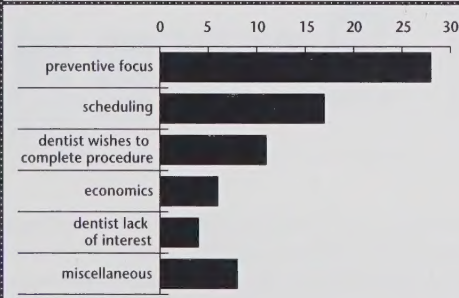
Types of practice where restorative skills were used



Reasons for not providing restorative dental services

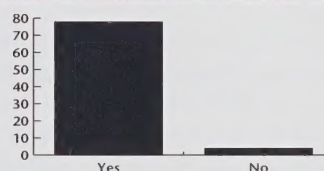


What office factors influenced not providing restorative services?

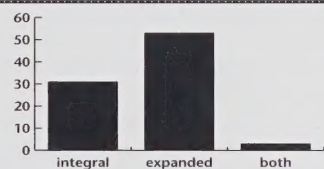


E. Beliefs and Attitudes of Dental Hygienists Toward Restorative Dental Services

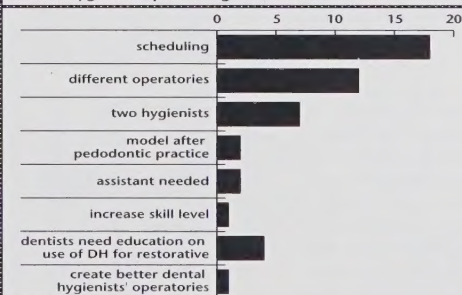
Have restorative skills enhanced your understanding of patients' overall dental health?



Do you think restorative is an expanded function of dental hygienists or an integral part of dental hygiene practice?

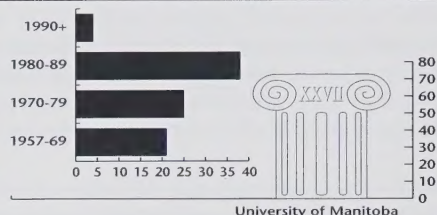


Suggestions or ideas for increasing the frequency of dental hygienists providing restorative services

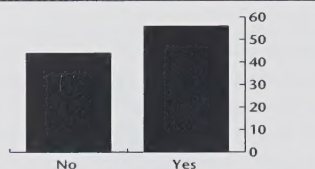


F. Demographic Data (Dentists)

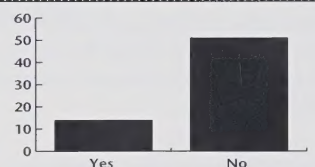
When and where did you graduate?



Have you ever had a dental hygienist practice restorative?



If not, would you be interested?



A number of dentist respondents identified that patient acceptance, or lack thereof, influenced the amount of restorative care provided by dental hygienists in Manitoba. This factor was not identified by the dental hygienists surveyed.

When a comparison is made between the dentists and dental hygienists, a similar outlook is revealed on issues of the demand for restorative dental hygienists, and of the factors influencing the utilization of restorative dental hygienists in private practice. The emphasis in many dental offices has turned to a periodontal preventive focus, and there is less demand for restorative dental services.

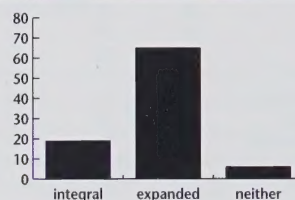
One area which is often neglected and overlooked is the polishing and finishing of amalgam and composite restorations. These could be easily done during recall appointments and would vastly improve the quality of restorations.

G. Specific Restorative Dental Services Provided by Dental Hygienists and Dentists' Interest in this Function

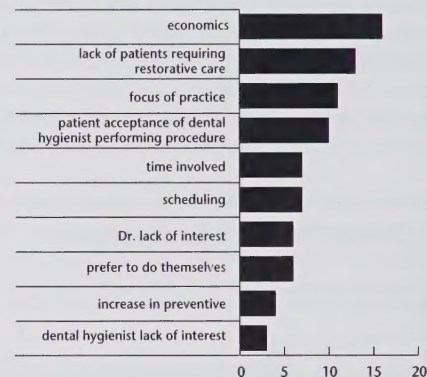
Services:	Never	Sporadic	Often	Daily	Interest (%)
rubber dam placement	37	29	6	10	10
matrix/wedges placement	43	20	6	18	12
liners/bases placement	42	19	6	17	13
condensing amalgam	39	20	8	18	16
carving amalgam	41	20	8	18	13
composite resin placement	43	23	4	17	13
finish/polish composite resin	47	18	6	14	14
preventive resin placement	27	19	18	18	16
temporary restoration placed	42	21	4	14	19

H. Beliefs and Attitudes of Dentists Toward Dental Hygiene Restorative Dental Services

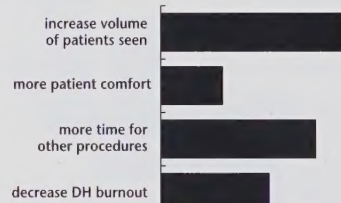
Do you think restorative is an expanded function or an integral part of dental hygiene practice?



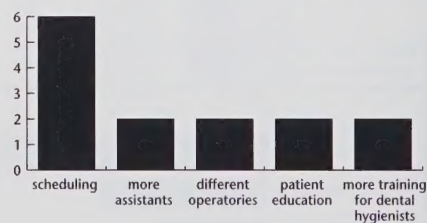
Reasons why a dental hygienist has not provided restorative services in the practice



How has your practice been enhanced with a dental hygienist providing restorative services?



Suggestions or ideas for office set-up that could increase the frequency of dental hygienists providing restorative services



Two issues that were overlooked in this study involve the specific duty of polishing and finishing amalgam restorations, and further interviews with dental hygienists who do, and do not provide restorative care. These oversights were unfortunate, and not intentional. The polishing and finishing of amalgam restorations may have made a slight difference

in how many different types of services are provided by dental hygienists in Manitoba. All the duties listed, including the above mentioned are legislated to dental hygienists. More in-depth interviews were not conducted primarily due to time constrictions. These would however help to enhance the information available on restorative care. Such an area is an ideal choice for new research projects.

Conclusion

Generally speaking the results of this survey are encouraging. At least 10% of dental hygienists in Manitoba are providing restorative care on a regular basis. This proportion is higher than that perceived by the majority of survey respondents. Thus, dental hygienists in Manitoba are in fact using the restorative skills they were trained to provide.

From the results, and comments made by dental hygienists in this study, the authors felt that there is a perception that when dental hygienists are practising restorative dentistry they cannot also practice periodontal care, i.e. they are just restorative dental hygienists. This scenario may be true for some office situations but is not the norm. In fact it is much more likely that restorative services are provided on certain days or as the need arises. Within the confines of this study, dentists who work with restorative dental hygienists have been able to organize an office system whereby the continuity of patient care between the dentist and the dental hygienist is smooth.

On the other hand, dentists who choose to do their own restorative work, view their dental hygienist in a more traditional role. The practitioners' roles in these offices are well defined with members of the dental team performing the skills for which they were primarily educated. This group also reports a concern in the economical side and patient acceptance side of such delegation. The economical issue is easily addressed. Educated dental hygienists can provide competent restorative care. As they gain experience in this role they will also gain speed and agility. The issue of patient acceptance is one that may take longer to resolve.

In the authors' opinion, there are a number of ways to increase the frequency by which dental hygienists provide restorative services. First, cooperative efforts on the part of dental hygiene associations and dental associations in educating the public regarding the skills that each member of the dental team possesses, would improve patient awareness and acceptance. Second, the introduction of a local anaesthetic program for dental hygienists that is either a mandatory component of the dental hygiene curriculum, or offered as a continuing education course, would allow for a greater continuity in services. However, the introduction of such a program would need to be preceded by new legislation to allow dental hygienists to perform this function.

Even if dental hygienists do not use their restorative skills following graduation, the ultimate benefit of this education is that their knowledge of dental materials, procedures, and the periodontal implications of restorative dentistry greatly enhance the dental hygienist's ability to design, implement, and evaluate clinical care which promotes and maintains oral health.

Reference

1. Report of the Working Group on the Practice of Dental Hygiene-Part one, *The Practice of Dental Hygiene in Canada*, Minister of Supply and Services Canada 1983, page 55-56



NATASHA KRAVTSOV, BA, RDH



CHRISTY CESSFORD, RDH

Natasha obtained her Bachelor of Arts Degree from the University of Winnipeg in 1988. Natasha graduated from the University of Manitoba, School of Dental Hygiene in 1993. She is presently employed in private practice in Winnipeg.

Christy received her diploma in Dental Hygiene from the University of Manitoba, School of Dental Hygiene in 1993. She is presently employed in private practice in Winnipeg.

ATTENTION

SIASST Dental Hygiene Graduates

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The CDHA Professional Conference in Saskatoon,
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for information.



Dental Implants: Are They For Me?, 2nd ed.

Thomas D. Taylor, DDS, MSD and
William R. Laney, DDS, MS.
Quintessence Publishing Co. Inc.,
Carol Hill, Illinois.
Copyright 1993: 60 pages, 48 illustrations.
List price \$25.00 US

Reviewed by: Marie A. Lohead, RDH, A.Sc.
Clinical Dental Hygienist
Fort Erie, Ontario

At a time when many clients are inquiring about implants, a text explaining what implants are, how they are placed, and their maintenance, is indeed, in great demand. Quintessence Publishing recognized a need of this proportion and has provided for the dental profession and the public, "Dental Implants: Are They For Me?", a publication to help educate our clients in regards to implants.

This book helps the dental professional explain implants in a simplified format. The large print and easily-understood dental illustrations makes this text pleasing to clients of all ages, especially senior clients. In the authors' opening statement, it is explained to the reader that the information given is generalized. The reader should understand that each person is an individual, therefore, the dentist is best qualified to determine specific individual needs.

The first part of this book offers information on implants used in joint replacement, and then the use of implants dentally. After a brief discussion on oral conditions that are suitable for the implants, the authors render greater detail on conditions, both dentally and medically, that can possibly contraindicate implant placement. The authors again advise the reader to consult with his/her dentist.

Once the basic background information has been established, the authors further explore various types of implants and placement. This is particularly helpful in explaining the diversity of types and style purposes.

The core of the text is devoted to the timetable of a typical course of treatment: from the start, which is inclusive of examination and diagnostic appointments, to achieving the finished product.

The last section concludes with oral hygiene instructions for the client to perform on a daily

basis. A variety of actual intra-oral photographs of a client demonstrating the techniques are included to help the reader better understand the home care.

I would recommend this text for not only the general dentist, but also for the specialist involved in implant placement. Dental hygienists would also find this text very helpful because of the variety of information. The book not only serves as a reference for general information, but also in conjunction as a visual aid to show the client at various stages of his/her progress. This text would also provide a good reference for the reception area for clients to view. I would, however, suggest this edition be available in a flip chart form with plastic laminated pages for ease of use in the operatory.

Ethics and Aging, Writings in Gerontology, No. 13

The National Advisory Council on Aging
Minister of Supply & Services, Ottawa, Canada.
Copyright 1993: 99 pages.
ISBN #0-662-20402-6

Reviewed by: Blossom T. Wigdor, CM, PhD
Chairperson, National Advisory Council
on Aging

Human services and social policies cannot be divorced from ethics: how we care for one another, individually and collectively, is fundamentally a moral issue. The aging of the Canadian population brings to the fore many ethical questions that previously may have seemed purely academic. These questions are of direct concern to legislators, service providers, administrators and most of all, to individual seniors and their families. To spark public awareness and stimulate discussion, NACA invited authors with expertise in the areas of ethics, law, health care and gerontology to address emerging ethical concerns in health care for seniors. These papers are guaranteed to be enlightening and provocative.

In the introductory chapter, Gary Kenyon and Warren Davidson outline the nature and scope of ethics and dispel some false ideas about what is meant by ethics. Ethics is not an arbitrary set of rules, a rigid list of 'Thou shalt not', nor a series of subjective whims; rather, it is an objective way of thinking about what human beings should do in specific situations, taking into account the best interests of everyone involved. Kenyon and Davidson argue that we should start with a thorough knowledge

of 'what is' in order to determine 'what ought to be'. When seniors are involved, ethical decision makers must go beyond stereotypes about aging and seniors and recognize their great diversity. In attempting to understand what seniors 'are', we must consider them first and foremost as persons; to see seniors as persons, we must try to grasp the 'inner' experience of aging, that is, how individual older persons see themselves and their lives. The articles that follow repeat the need to consider the heterogeneity among seniors in determining the right course of action for any particular senior or group of seniors. Also repeated is the importance of taking into account the individual's perspective of a situation and his or her values and feelings.

Jocelyne Saint-Arnaud then presents in systematic detail the ethical principle of respect for persons, and how this principle is embodied in the individual's right to autonomy and to self-determination in health care. The free and informed consent of the individual patient must be obtained for any treatment; the patient has the right, at any time, to refuse to have a treatment administered and the right to have treatment withdrawn, even if this refusal entails a possibility of death. Similarly, the patient has the right to choose to live 'at risk'. A crucial condition of exercising the right to self-determination is mental competence. Professor Saint-Arnaud describes the various means by which seniors can assure that their wishes for treatment are followed by the health care team in the event they become mentally incompetent, notably powers of attorney, advance health care directives and living wills. Her article concludes with some thoughts about the limits of individual rights, with specific reference to euthanasia: should a person have the right to ask others to actively put an end to his or her life?

Bill Harvey's paper complements the presentation of patients' rights by discussing the ethical principles guiding health care professionals in the care of older patients. Health professionals, individually and in health care teams, are ethically bound to promote the patient's global well-being. This includes physical as well as social, emotional and, perhaps, spiritual well-being. In addition to the ethical dilemmas posed by the patient's illness (e.g., "Should I relieve suffering or prolong life, given the patient's condition?"), health professionals face ethical difficulties when the patient's values or decisions conflict with

theirs. Professor Harvey warns against the questionable use of competency assessments to limit a patient's right to decide in these instances. He challenges health care professionals to seek ways of enhancing patient autonomy, especially for patients who are becoming increasingly dependent, rather than imposing their personal or professional values on them. Ethical responsibilities for patients extend to health care teams, who are called upon to develop morally authoritative team decisions, and to institutions, who are obligated to provide a moral community. Multi-disciplinary ethics committees are discussed as only one means of creating an institutional moral community.

The ethics of health care go beyond individual relationships between seniors and health care providers or researchers: health care is a social resource that must be fairly distributed to all members of society. Kathleen Cranley Glass describes the current debate regarding the allocation of health care in an aging society. What criteria can be used to distribute resources fairly? Is age an ethically justifiable basis for allocating health care? Arguing that individual need, regardless of age, is the only morally sound basis for deciding who gets

health care, Dr. Cranley Glass offers alternative suggestions to guide decision-making in health care, that rest upon an assessment of the effectiveness of treatment and upon the rights of patients to limit treatment.

Advances in diagnosis and treatment often result from clinical research efforts; thus, research is a moral 'good'. However, as Abbyann Lynch describes in her article on the ethics of research involving seniors, the social benefits sought by research must be carefully weighed in relation to the potential harms it may cause — to individuals participating in research and to groups who are supposed to benefit. The rights of prospective research participants for respect and self-determination are the same as those of patients. The responsibilities of researchers and authorities who grant approval for research to avoid harming participants are perhaps even greater than the responsibilities of health care professionals to patients because research participants are volunteers who put self-interest aside for the good of others. The wide diversity of seniors' capacities and vulnerabilities is important to consider in determining the nature and extent of possible harm to elderly research subjects. Dr. Lynch points out the ethical and legal

problems in conducting research with incompetent persons. The greatest ethical challenge, however, is not one of respecting individual rights, avoiding harm or ensuring justice; rather, it is the obligation of all parties involved in approving and in implementing research to apply the results of research to achieve the intended social good.

Throughout the papers, fundamental ethical values, principles and rules are frequently invoked. To guide the reader in these presentations, a short glossary of ethical terms is provided. The glossary is not intended to offer standard definitions, because there is as yet no clear consensus among ethicists regarding these terms.

The Council expresses its sincere gratitude to the ethicists who have generously contributed their expertise to this *Writings in Gerontology*, and to the Council's Education committee, under the direction of Louise Francoeur, who reviewed the articles for their pertinence, completeness and accessibility to NACA's readership. Thanks are owed as well to the NACA staff members, Louise Plouffe, Francine Beauregard and Renee Blanchet, who brought the report to fruition.

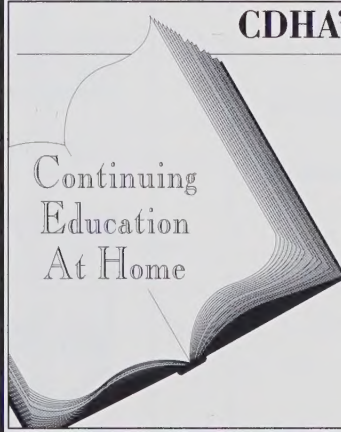


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January:

An Open Future: A Shared Vision

National Health Policy Reform Project

CHA Press, Ottawa, ON ISBN #0-919100-73-2

February:

Choices and Conflict:

Exploration in Health Care Ethics

Emily Friedman

American Hospital Publishing, Inc.,

Chicago, IL ISBN #1-55648-082-2

		<i>SPONSOR</i>	<i>LOCATION</i>	<i>FOR INFO CALL</i>
January 1994				
22	CPR for the Dental Team – Dr. R. Boyar, Mrs. J. Woods	University of Manitoba	Winnipeg, MB	(204) 789-3331
29	Common and Important Diseases of the Oral Mucosa	Dalhousie University	Halifax, NS	(902) 494-1674
February 1994				
10	Contracts vs. Hourly Wages – Mark Waltersdorf, CA	NADHS	Edmonton, ALTA	(403) 482-3460
12	Local Anesthesia – Dr. Brenda Scarfe	SDHA	Regina, SASK	(306) 781-4437
19	Occlusion – Dr. P. Kirveskari	College of Dental Surgeons of Saskatchewan	Saskatoon, SASK	(306) 244-5072
20-27	Superior Esthetics: Achieving A Successful Smile – Dr. Keith Compton, – Dr. Jim Maroney, – Dr. Jean O'Neal	University of Alberta	Western Caribbean Cruise	(403) 492-5023
March 1994				
9	The Compromised Patient – Dr. Pereneck	Central Alberta Dental Hygiene Study Club	Red Deer, ALTA	(403) 347-9855
10	Humour in the Workplace – Anna Fodchuk	NADHS	Edmonton, ALTA	(403) 482-3460
12	Working Without Injury: Ergonomics & Back Stress – Mrs. Marg Friesen	University of Manitoba	Winnipeg, MB	(204) 789-3331
19	The Computer — Introduction & Hard Disk Management	SDAA	Watrous, SASK.	(306) 747-3504

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The program usually requires two academic years to complete and consists of didactic courses and original research.

Closing date for receipt of fully documented applications is **March 31, 1994 for admission in September.**

Further information and application forms may be obtained from:



The Graduate Advisor
Department of Clinical Dental Sciences
Faculty of Dentistry
The University of British Columbia
2199 Wesbrook Mall
Vancouver, B.C. V6T 1Z3
Tel: (604) 822-5898
Fax: (604) 822-3562

The University of British Columbia Faculty of Dentistry Dental Hygiene Degree Completion Program

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Closing date for receipt of fully documented applications is **April 15, 1994 for admission in September.**

Further information and application forms may be obtained from:



The Secretary, Division of Periodontics
Department of Clinical Dental Sciences
Faculty of Dentistry
The University of British Columbia
2199 Wesbrook Mall
Vancouver, B.C. V6T 1Z3
Tel: (604) 822-5898
Fax: (604) 822-3562

Canadian Dental Hygienists Association Community Health Audiovisual Aid Library

AVA LIBRARY

Seniors

Packages

- I "Oral Health in the Elderly: A Workshop Curriculum and Teacher's Guide" (2 available)
- II "Oral Health Education for the Elderly ...A New Preventive Dental Care Program" (1 available)
- III "Training and Motivational Materials in Geriatric Dentistry" (1 available)

Manuals

- IV "Geriatric Oral Health: A Training Manual for Long Term Care Facilities" (2 available)
- V "Assessing the Aging Mouth" (1 available)

Slide-Script Set

- VI "Senior Smiles" (2 available)

Videotapes

- VII "12-Minute Videotape (VHS) for the Elderly" (In French only — 2 available)
- VIII "Options: Dental Health in Later Years" (2 available)
- IX "The Senior Smile" (2 available)
- X "Oral Health and the Elderly" (1 VHS available)

Special Needs

Slide-Script Set

- I "Prevention and Treatment Considerations for the Dental Patient with Special Needs"

Children

Videotapes

- I "Toothbrushing with Charlie Brown" (2 available)
- II "It's Dental Flossophy, Charlie Brown" (2 available)
- III "The Barnyard Snacker" (2 available)
- IV "The Haunted Mouth" (2 available)

Other

Videotapes

- I "Fluoride — The Magnificent Mineral" (2 available)
- II "Fantastic Fluoride" (2 available)
- III "Oral Problems of Patients with AIDS and HIV" (1 set available in English/ 1 set available in French)
 - Part I a) Dr. Norbert Gillmore
b) Mr. Rick Hatt
 - Part II "The Global Occurrence of AIDS"
 - Part III "HIV Associated Periodontal Disease"
- IV "Prescription for Periodontal Health" (2 available)
- V "More Than Just a Pretty Smile" (1 available)
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- I Community Action Pack (1 available)

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CANADIAN DENTAL HYGIENISTS ASSOCIATION

5th Annual Professional Conference

June 17-19, 1994 • Delta Bessborough Hotel
Saskatoon, Saskatchewan



SHARPEN YOUR PROFESSIONAL EDGE:



"A Question of Conscience – A Matter of Choice"

We are pleased to announce that **Pamela Wallin**, co-anchor of CBC's *Prime Time News* will be the Opening Guest Speaker on Friday afternoon, June 17.

Veteran broadcast journalist Pamela Wallin is co-anchor of CBC *Prime Time News*.

Wallin, former co-host of CTV's *Canada AM* and anchor of CTV's weekly political forum *Question Period*, has worked as a broadcast journalist for 20 years. She was this year's winner of the Gordon Sinclair Gemini Award for best overall broadcast journalism.

Born in Saskatchewan, Wallin began her career at CBC Radio in Regina as co-host of a noontime open-line program. She spent the next six years on air and behind the scenes at CBC Radio in Regina, Ottawa and Toronto, working on such programs as *Sunday Morning* and *As It Happens*.

Wallin was a political reporter for *The Toronto Star* in Ottawa and a regular panelist on CTV's *Question Period* before joining the private network in 1982 as Ottawa-based host/reporter for *Canada AM*.

In 1985, Wallin became the first woman in Canadian network television history to be appointed bureau chief when CTV put her in charge of its Ottawa bureau. In addition to her anchoring responsibilities on *Question Period*, Wallin anchored several CTV News specials, including coverage of the Gulf War. She has conducted CTV's annual year-end interview with the prime minister since 1984.

Ms. Wallin was a 1987 Gemini nominee for Best Reportage for "The White Paper on Tax Reform" and was honoured as an "outstanding Canadian achiever" at a dinner hosted by Her Majesty Queen Elizabeth II in 1982, when she covered the patriation of the Canadian constitution.

In 1987, she reported from the Philippines on Corazon Aquino's rise to power, and she was stationed in Buenos Aires in June 1982 to file daily reports on the Falklands/Malvinas War. She was one of the few journalists to be on location throughout much of the crisis and the sole female television correspondent from Canada.

Wallin anchored the weekend edition of CTV News on a semi-regular basis from 1988 until last year when she rejoined *Canada AM*. A graduate of the University of Regina, Wallin has an honours degree in psychology and political science.





The Canadian Dental Hygienists Association presents its 5th Annual Professional Conference Preliminary Program — Main Events



FRIDAY, JUNE 17TH, 1994

1:00 - 5:30 pm

Opening Greetings

Guest Speaker — Pamela Wallin

Guest Speaker — Dr. Michael Rachlis

"Saving Medicare — The Power and The Glory"

Class Reunions

SATURDAY, JUNE 18TH, 1994

8:30 - 5:30 pm

Guest Speaker — Mr. Brent Cotter

"Dental Hygiene & Health Care — Coming to Terms with the Ethical and Moral Dilemmas"

Ms. Marg Wilson

"Decision Making Process for the 90's"

Ms. Jenny Thomas

"Nobody Told Me There Would Be Days Like This"

Dr. Gary Chiodo

"Applied Ethics in Dental Hygiene Practice — Voicing Our Value"

Commercial Exhibits, Poster Session, Table Clinics,

Free Papers, Lunch Buffet

Evening Social at the Western Development Museum — Dinner and Entertainment

SUNDAY, JUNE 19TH, 1994

8:00 am - 3:00 pm

Ms. Maxine Borowko

Ms. Lynn Guest

"New Clients/New Settings/New Questions"

(Ethical dilemmas to consider when meeting the needs of special clients groups)

Panel I

1) *"Can Ethics Be Learned?"*

Panel II

2) *"Ethics of Access to Care"*

Brunch

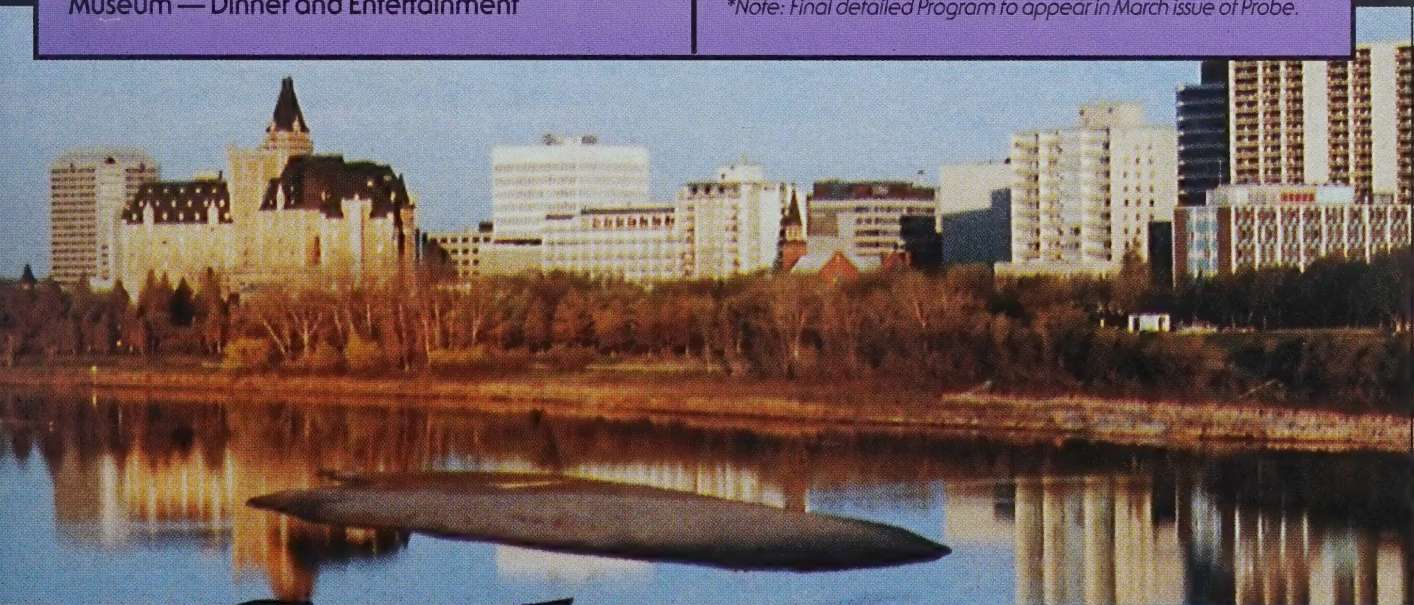
Ms. Tobelle (Toby) Segal

"The California Vision" (or How a Peace Time Manoeuvre Turned Into a War)

Panel III

3) *"New Practice Arrangements"*

**Note: Final detailed Program to appear in March issue of Probe.*



Saskatoon Conference

Registration Form 1994

CDHA Member

Full Registration: on or before May 1, 1994 \$215.00 (GST incl.)
after May 1, 1994 \$265.00 (GST incl.)
Daily Registration: on or before May 1, 1994 \$100.00 (GST incl.)
after May 1, 1994 \$130.00 (GST incl.)

Please contact your provincial licensing body for continuing education points applicable.

Allied Health Professionals/Public

Full Registration: \$400.00 (GST incl.)
Daily Registration: \$150.00 (GST incl.)

*Full registration includes access to professional programs, reception, breaks, luncheon and social events.
Daily registration includes access to professional programs of the day, plus lunch and breaks (does not include social).*

Students (Full-Time Dental Hygiene Only)

Full Registration: Free for lectures only (does not include socials or meals)
\$100.00 (GST incl.) includes luncheons, breaks and reception (not social)
Daily Registration: Free for lectures only
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Social Tickets – Western Development Museum Dinner: \$35.00 extra for all registrations where social is not included.

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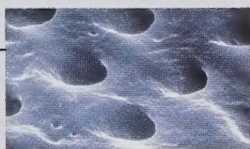
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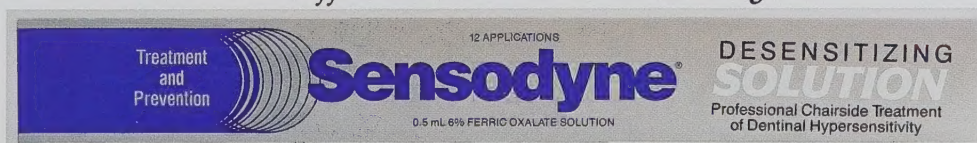
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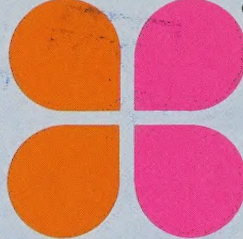
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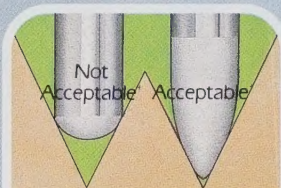
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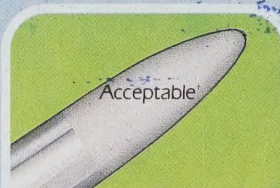
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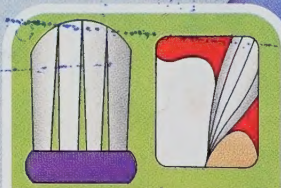
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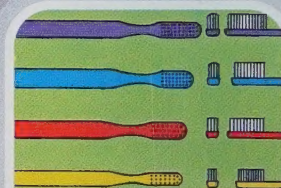
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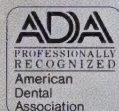
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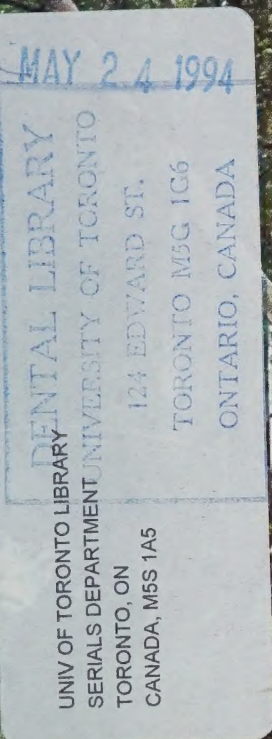
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THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
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DES HYGIENISTES DENTAIRE

PROBE

VOL 28, NO 2

MAR/APR 1994 MAR/AVR

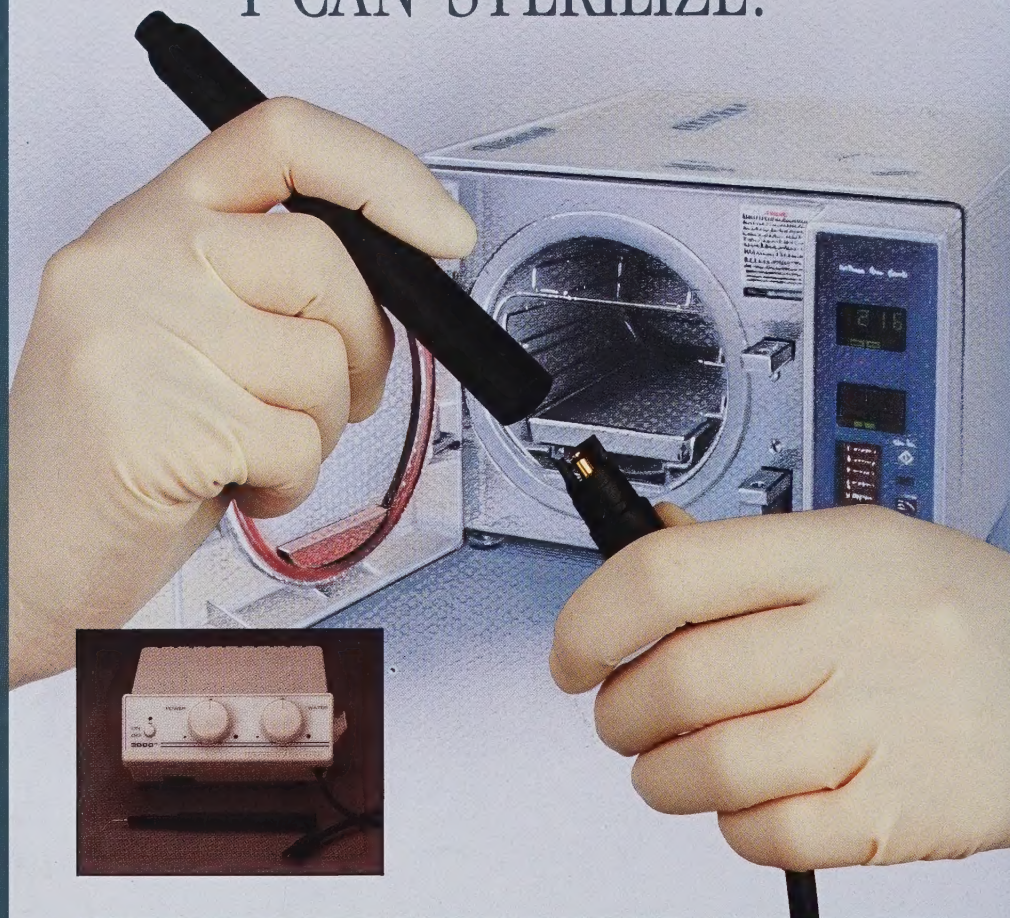


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Diversification: Thoughts to Ponder

PRESIDENT'S MESSAGE

A series of recent events has challenged me to review who I am and what I do; all in relation to the practice of dental hygiene. Has this ever happened to you? Have you ever been faced with the question of who you really are when it comes to the profession we have chosen.

One of our faculty was away, so I took the opportunity to teach in one of our first year dental hygiene clinics. (I often do sick relief etc. in both dental hygiene and dental assisting since it keeps me in touch with the students and helps keep the school on budget!) One of the first year students asked me if I really had the time to do much clinical practice these days, when I replied in the negative, he then asked me if I would lose my license to practice! At first the question puzzled me, but my answer was "No, there are more ways to practice dental hygiene than just in a clinical setting." He seemed satisfied with this explanation and continued with his work.

Workloads in our faculty have been redistributed this year due to a maternity leave. We viewed this as an opportunity to invite the senior dental hygienist from the Regional Health Unit to teach the Health Promotions Class to the second year dental hygiene students. She is eminently qualified, as she has spent many years in community health and currently is a member of the Provincial Task Force on Health Care Reform. She asked, with some trepidation, if she would be expected to teach clinical also! Clinic is not her area of expertise, health promotion is!! We have clinicians whose areas of expertise do not include community health.

Continuing education is mandatory in the province in which I currently reside. The licensing body does not always accept non dental or soft courses, i.e. stress management, as eligible for continuing education credits. Recently we had to ensure that the title of a course met the licensing body's criteria, not those of our profession. Hopefully this will change when dental hygiene becomes self-regulating. Presently, a course in periodontics carries more weight than a course in office management or patient relations? Is there something amiss here?

An administrator from a different discipline asked why I continued to be so involved



FRAN RICHARDSON COTTON
RDH, BScD, MEd

in dental hygiene and why it was important for me to retain my licence if I was not "practising"? The intimation of course was, if you are not in clinical practice then perhaps you are no longer a dental hygienist. Have we as a profession fostered this concept? Have we as an association perpetuated this myth?

Today many dental hygienists enter the profession having previously experienced related or unrelated education and/or careers. They bring to the profession a wealth of knowledge and skills that can only enhance and strengthen the many facets of dental hygiene. Many will combine the unique skills of dental hygiene in other career paths. The possible combinations are endless! We should not stifle this creative force but celebrate and promote our differences. But at the same time, let us support those for whom clinical practice was the first step by never forgetting that clinical practice was, and still is, the basis of what we do and who we are.

As dental hygienists choose and are chosen to move in directions that don't always involve clinical practice, we, as an association must continue to support and embrace colleagues with a different destiny. None of us want to forget our roots by completely distancing ourselves from the clinical aspect of our profession. But as educators, we are obligated to provide students with the knowl-

edge and skills necessary to access opportunities in a variety of paths. As colleagues, we should encourage this diversification. We should appreciate the dental hygienist who is a trail blazer; one who seeks a career encompassing many of the roles dental hygiene practice has to offer.

During my career lifetime, the scope of dental hygiene practice has changed significantly. With the year 2000 rapidly approaching, several CDHA Past Presidents articulated their vision for the future of Dental Hygiene as one of increased growth in professional responsibility. I look forward to the day when I don't have to explain who I am as a dental hygienist especially to other dental hygienists and health professionals! Our nursing colleagues jumped that hurdle many years ago.

I consider myself very fortunate. My story includes aspects of dental hygiene in which I have, and continue, to practice as a clinician, educator, health promoter, researcher and administrator. Today, my primary responsibilities lie in administration. When I meet with other health education administrators I am proud to state that I am a Dental Hygienist. Yes, sometimes I have to explain who I am; but, I am also willing to learn who my administrative colleagues are.

I have never shied away from new experiences; to travel a path yet untrod. I welcome the appearance of new challenges. With hard work and perseverance, I expect to conquer and/or manage them. Choosing Dental Hygiene as a career has not only afforded me many and varied challenges, but also provided me with the capability to meet and master them. In my heart of hearts I will always be proud to be a Dental Hygienist! 

Fran is currently Chair, Division of Dental Studies and Acting Chair, Nursing and Social Services, College of New Caledonia, Prince George, BC. She received her diploma in Dental Hygiene from the University of Toronto in 1971, a BScD from the University of Toronto in 1982 and a Masters in Education from the University of Regina in 1987

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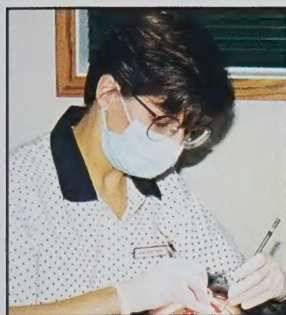


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COVER

This month our cover features colleague, Nina Kuyt and her son, John. Nina is a Dental Hygienist practicing in Yellowknife, NWT and when not working she enjoys exploring Canada's North. She has lived in Yellowknife for a year where she works part time at the Adam Dental Clinic. She also does some orthodontics when the orthodontist from Edmonton comes up to provide services to Yellowknife residents. She says her perio experience allows her to offer some "advanced" scaling and root planing skills to the many patients who require perio treatment. She is a graduate of George Brown College (1981) and worked in Calgary for seven years, travelled throughout the Pacific Rim for a year, and worked in Ontario in an ortho-perio practice prior to moving North.

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Go For It!!

National Dental Hygiene Campaign — A Flurry of Activity Across the Country

"The National Dental Hygiene Campaign was great this year", says Dawn Mueller, the campaign's national coordinator. She attributes its success, in part, to the fact that the campaign was organized and launched much earlier this year. Each Provincial Coordinator was sent an updated version of the Horner manual in April and samples of campaign materials in both French and English were mailed to all CDHA members with their July/August issue of Probe.

Mueller says there were a wide variety of interesting and innovative activities conducted during the week which did much to promote the profession. Some of the activities included mall displays, banners and billboard displays, school presentations/lectures, media coverage, distribution of dental hygiene fact sheets, visits to day care centres and seniors' residences, dental office tours and slide presentations. She noted that in British Columbia a native day care centre and several seniors centres actually requested visits — which in her opinion "shows that people are becoming more aware of dental hygienists".

North Okanagan dental hygienists arranged numerous events, including a puppet show at a local day care centre, a dental health lesson for the Hillview Cubs, an oral cancer

awareness presentation for members of the Canadian Cancer Society, a dental lesson for members of the North Okanagan Neurological Association and donations of dental supplies to the Transition House of Vernon. Their efforts were publicized in the Lumby Times, the Morning Star and the Vernon Daily News. Congratulations to a dedicated group of individuals who undoubtedly brought the profession to the forefront in their community.

The six components of the New Brunswick Dental Hygienists' Association also actively promoted the dental hygiene profession during the 1993 National Dental Hygiene Campaign. NBDHA President, Diane Charron, was interviewed on MITV and publically promoted oral health and the dental hygiene profession. Dental hygienists in Saint John addressed members of the Saint John Boys and Girls Club and celebrated NDHW by going on a nature walk.

Moncton dental hygienists produced radio announcements broadcast during the week, prepared news releases, staffed a booth at the YMCA's Career Expo, presented oral health education programs to Grade 3-5 classrooms and Boy Scout and Girl Guide groups, and distributed toothbrushes, donated by local dental offices to the pediatric wards of two hospitals. Fredericton dental hygienists also prepared radio public service announcements, gave oral health presentations to kindergarten classes and the principals of three school districts, a MOM's Group and a

YMCA Immigrant Group. In Miramichi, local radio and TV stations broadcast daily information taken from the CDHA fact sheets



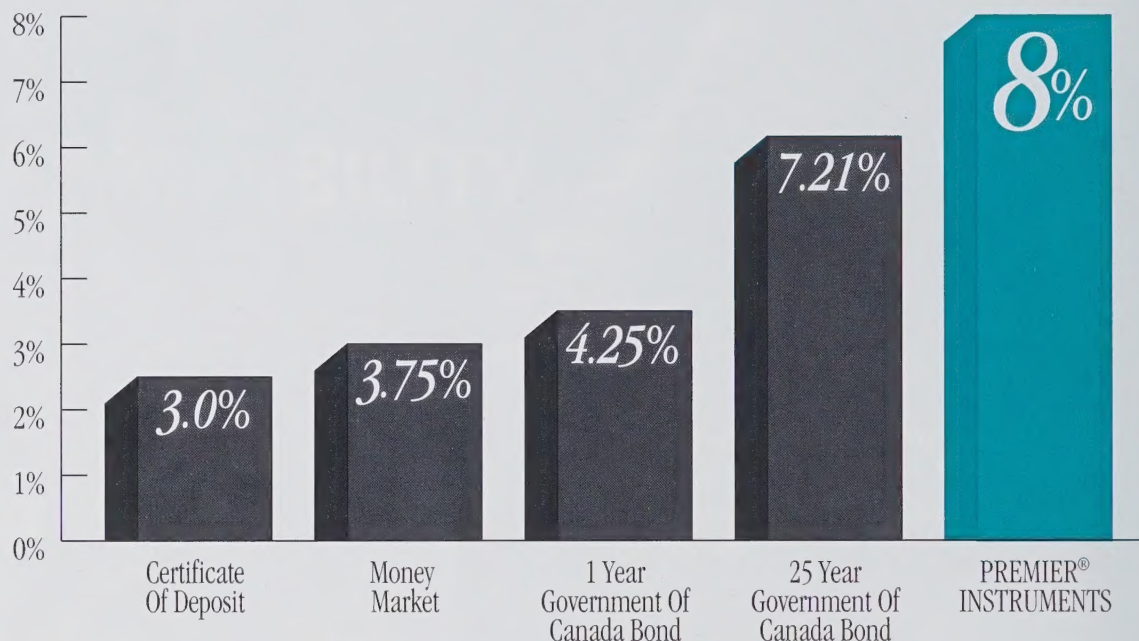
during NDHC and dental hygienists were recognized as "citizens of the day". Newspapers in Bathurst and Upper St. John River Valley provided excellent coverage of activities organized by dental hygienists, which included visits to Cub groups and a discussion with local Pharmacists regarding the new fluoride recommendations.



Members of Canada's Armed Forces participated in the 1993 National Dental Hygiene Campaign (top right). Pictured here with a display of information for public consumption (l-r) CPL Suzanne Jean, CWO Denis Cote and Sgt Annette Lang-Bouchard. In addition to developing the mall display, the team visited a day care center. In St. John, New Brunswick dental hygienists participated in a 2-hour walk around Irving National Park to literally kick off the week (left); later in the week, dental hygienists conducted presentations about dental health at the Saint John Boys and Girls Club. Pictured above are Stacey Fairweather, Trudy McAvity and Anne Ryan (inset) conducting an information session at the Saint John Boys & Girls Club.

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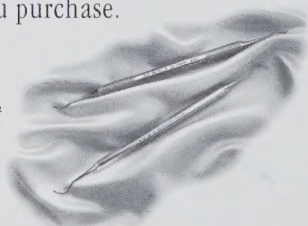


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The annual National Dental Hygiene Campaign will continue to promote public awareness of the Dental Hygiene profession with its 1994 focus on Teens, scheduled for the week of OCTOBER 16-23. It's not too early to begin thinking about your own involvement in this year's campaign, either by adapting one of the ideas used last year or by creating your own unique initiatives. More information on the campaign and materials that will be available will be published in upcoming issues of Probe. Every effort made increases our visibility in the public eye! — GO FOR IT!

Alberta dental hygienists targeted school age children in Edmonton, Lethbridge and Calgary. Dental Hygienists from Edmonton gave presentations to several Boys and Girls

Clubs, dressed in a tooth mascot costume and distributed stickers, fact sheets, tooth brushing charts and aquaflex toothbrushes at a McDonalds and at a Mall display.

Lethbridge dental hygienists arranged for dental inspections and a "toothbrush swap" (students toothbrush in exchange for a Crest kit) for a Grade one class, a electronic billboard with the message, "Behind every great smile . . . is a dental hygienist" and advertisements for local newspapers and TV stations. Prizes for a toothbrush draw (guess how many brushes were in the container) were delivered in magnificent balloons from Balloonabstractions to the winners at their school. Calgary dental hygienists made presentations to 14 Brownie and Guide groups, displayed posters at elementary schools and sent press releases to community newsletters and radio stations.

One particularly noteworthy activity, developed by a dental hygienist residing in northern B.C., involved a project in which elementary school children were asked to describe what a Dental Hygienist meant to them. Although we have not had the opportunity to review the submissions, it certainly would be interesting to learn what they knew. This would be an interesting question to pose to the public at large! We may be surprised at what we learn and it would undoubtedly help us to determine how and what we should be doing and saying to increase the profession's profile in future campaigns.

Calcium intake of teenage girls affects future health Inadequate intake during adolescence could lead to osteoporosis in later life

(NC)—New research shows the importance of the calcium intake of teenage girls in preventing osteoporosis. This condition where bones become thin, weakened, and more likely to break as the body ages strikes a startling one in four women. Yet despite the evidence of calcium's preventative role, teenage girls in general do not consume enough calcium.

The most important protective measure against osteoporosis is the bone mass that women achieve by and during adolescence, the period when most bone growth occurs. The second factor is the rate of bone loss after menopause.

However, American nutrition surveys show that adolescent girls not only fail to increase calcium intake when their calcium needs are greatest, but they actually decrease their intake, selecting calcium-rich foods less often.

A study completed this August at the Pennsylvania State University reinforces the impact of this calcium shortage. T. Lloyd and his colleagues conducted the first longitudinal study to determine the effects of calcium supplementation on bone mass in healthy, white adolescent girls during an 18-month period. The 94 girls, one

Nutrition EQUALS HEALTH

month short of their 12th year at the beginning of the study, were divided into groups that were identical with regard to age, height, weight, and body mass index. The girls were matched for pubertal stage, because pubertal stage is known to influence bone mass.

One group received a daily calcium supplement, the other a placebo pill. The researchers assessed dietary calcium intake by three-day diet records at the beginning of the study and also at six-month intervals. The mass of the lumbar spine and the total body was also assessed at the same intervals.

Calcium intake from dietary sources averaged 960 mg daily for the entire study group, less than the requirement for calcium of their age group. The supplemented group received on aver-

age 40% more calcium than the placebo group and more than the recommended requirement for calcium.

The supplemented group showed a significantly greater increase in the bone density and bone mineral content of the lumbar spine and the total body than the placebo group. This result also indicates greater overall skeletal mineral acquisition.

By age 12, the adolescent girls had already achieved about 50% of their adult bone mineral density. An increase of even a few percent points during the six to eight years remaining to acquire adult bone status may provide significant long-term benefits.

Even this modest increase may ensure the attainment of the optimal development of peak bone mass, which could lower the risk of osteoporotic fractures later in life. The overall growth pattern of the two groups was identical, indicating that calcium alone was responsible for the increases observed in bone mass.

These results indicate that the future health of adolescent girls could be harmed if they do not maintain adequate calcium intake. The failure to attain peak bone mass during adolescence might adversely affect their risk of osteoporosis in later life.

CDHA/ADHA/ IFDH Liaison Meeting



Representatives of the Canadian Dental Hygienists Association, the American Dental Hygienists Association and the International Federation of Dental Hygienists had an opportunity to compare notes while attending the North American Research Conference held in Niagara Falls last October.



Dental Hygiene Concerns Crossing Borders — Nationally and Internationally

From left to right: Ruth Nowjack Raymer, IDHF President; Fran Richardson Cotton, CDHA President; Carol Matheson Worobey, CDHA Executive Director; Kathleen H. Alzare, ADHA President-Elect; Lorraine Boomhour, CDHA Past President; Ellen Brownstone, CDHA/IFDH Representative; Sarah A. Turner, ADHA President; Marg Reveal, ADHA/IFDH Representative.

Our Apologies

In the January/February issue of *Probe* we misspelled the name of the author of the scientific article entitled, "Qualitative Research, Education and Dental Hygiene". The author is **Sherry Woitte**, RDH, BED, MED.

MARCH IS NUTRITION MONTH

A message from:

The Canadian
Dietetic
Association



The
Dietitians of
your Province

and the 1994 Nutrition Month Official Sponsors:



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CDHA's Immediate Past President Visits PEI and New Brunswick



CDHA Past President, Lorraine Boomhour, travelled to Atlantic Canada in November to meet with New Brunswick and Prince Edward Island Dental Hygienists Association members.

During the New Brunswick Dental Hygienists board meeting numerous issues were discussed, including self-regulation. Ms. Boomhour shared what was happening across Canada in this regard. Following the board meeting, a record number of attendants participated in a Continuing Education seminar hosted by the New Brunswick Dental Hygienists Association. The seminar included a presentation delivered by Dr. Rinehart-Dual, specialist, orthodontist and periodontist. Ms. Boomhour says Rinehart-Dual's presentation was "excellent" and a second presentation on employment standards and policies was also "very enlightening".

Ms. Boomhour addressed the participants in the afternoon and thanked the President of the New Brunswick Dental Association's Board, Diane Charron, and the association's directors on the professional and efficient manner in which they carry out their responsibilities.

The address concluded with some insight into new developments at CDHA — including the recent debut of a "Members Manual" detailing the structure of CDHA, the increased publication of *Probe* and *Explorer*.

Ms. Boomhour then had the opportunity to visit Prince Edward Island. Lorraine used the day to present a CDHA Quality Assurance Workshop to the members of the Prince Edward Island Dental Hygienists Association. The opportunity for sharing practice experience and learn from one another is always rewarding.

CDHA, on behalf of Ms. Boomhour, thanks PEIDHA for their hospitality.



Left to right: Lorraine Boomhour, CDHA Immediate Past President; Dianne Charron, NBDHA President; Sharyn Milroy, CDHA Director.

Family Violence Resource Materials for the Dental Community : An Annotated Bibliography

Available to Dental Professionals at no charge

In an effort to stimulate the dental community's awareness of, and interest in, the important issue of family violence, an Ad Hoc Advisory Group was initiated in the fall of 1992 by the Mental Health Division of Health Canada. Members of the advisory group include Joan Simpson and Sharon Amer of the Health Services Directorate, Health Canada; Jenny Thomas, Canadian Dental Hygienists Association; Lizette Chevette, Canadian Dental Assistants Association; and Dr. Elizabeth MacSweeney, Canadian Dental Association. Meeting on a quarterly basis for one year, the group developed articles for continuing series and theme issues in professional journals; an annotated bibliography of resource material; an update on curricula and accreditation issues, and initial consideration of practice guideline development/adaptation.

The publication entitled *Family Violence Resource Materials for the Dental Community: An Annotated Bibliography* includes a section dealing with the possible role of the dental community in family violence issues as well as a list of over 60 references about violence and abuse. It provides a valuable resource for oral health care professionals. Copies are available free of charge by writing: Publications, Health Canada, 19th Floor, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario, K1A 0K9



Advisory Group on Family Violence
Standing (l-r): Dr. Elizabeth MacSweeney, Sharon Amer
Seated (l-r): Lizette Chevette, Joan Simpson, Jenny Thomas

Canadian Hospital Association Urges New Government to Work with Consumers and Providers to Reform Canada's Health Care System

Canada's new Health Minister, Diane Marleau, has been asked to give the highest priority to setting up the proposed National Forum on Health, in partnership with the provinces and health care stakeholders, by the Canadian Hospital Association (CHA).

In a news release dated November 17, 1993, CHA notes that "such a forum could well provide the means for improving and maintaining our current health system within a viable fiscal framework". According to the CHA, the real solution to Canada's health care concerns lies in capping health expenditures at a defined, negotiated and agreed-upon level, and defining and delivering clinically necessary services as efficiently as possible within that closed funding envelope.

According to the release, CHA "is forging ahead with realistic proposals for a preferred health system". The association recently produced the National Health Policy Reform Project — *An Open Future: A Shared Vision. The Vision Report* is the fruit of two years' in-depth consultation with member and sister health associations, health service managers and providers, consumers, academics, researchers and futurists from across the country.

The Canadian Hospital Association is a federation of eleven provincial and territorial hospital/health associations representing 1,200 health care facilities and agencies. It is the national voice of health care facilities and agencies in Canada.

Ontario Dental Hygienists Achieve Self-Regulation

On December 31, 1993, the governance of the professions of dentistry and dental hygiene in Ontario changed. The *Health Disciplines Act*, which governed both professions since 1974 was repealed and the *Regulated Health Professions Act*, the *Dentistry Act*, and the *Dental Hygiene Act* were proclaimed into force.

In January 1994, the Royal College of Dental Surgeons of Ontario (RCDS) issued a "Profession Advisory" to the dentists of Ontario to provide them with information about the change. The information that follows is excerpted from the RCDS Advisory.

The guiding principles behind the new legislation are to:

- protect the public, to the extent possible, from unqualified, incompetent, and unfit health providers;
- develop mechanisms to encourage the provision of high quality care;
- permit the public to exercise freedom of choice of health care providers within a range of safe options; and
- promote evolution in the roles played by individual professions and flexibility in how individual professionals can be utilized, so that health services can be delivered with maximum efficiency.

Along with the principles of public protection and accountability, this legislation set out a new system of regulating the health professions' scope of practice or areas of permitted practice. The system is based on the principle that the sole purpose of professional regulation is to protect the public interest, and not to enhance any profession's economic power or status.

It is the Government's view that the old system,

where a health professional had an exclusive licence or monopoly over the provision of services that fell within his/her scope of practice, does not protect the public and inhibits innovation making it more difficult to provide the best service at the lowest cost.

One of the key differences between the new Regulated Health Professions Act (RHPA) and previous legislation, with respect to dental hygienists, is that under the new legislation, dental hygienists are governed by their own regulatory body — the College of Dental Hygienists of Ontario (CDHO). Dental hygienists are now legally entitled to perform their "authorized acts" of scaling and root planing without the supervision of a dentist provided that the procedures have been "ordered" by a registered dentist.

According to the Dental Hygiene Act, a dental hygienist is authorized to perform the following procedures when these procedures are "ordered" by a member of the Royal College of Dental Surgeons of Ontario:

1. Scaling teeth and root planing including curetting surrounding tissue. (This does not mean surgical curettage.)
2. Orthodontic and restorative procedures.

"Ordering" refers to requesting a procedure from a person legally entitled to perform that procedure. A dentist "orders" a procedure not a person.

Increased practice autonomy is inherent in self-regulation. Undue restriction of access to the services of a dental hygienist by positioning the dentist as a gatekeeper between the public and the hygienist runs contrary to the principles of the RHPA.

Report on the Canadian Dental Association's 37th Teaching Conference: *Is There a Future for Hospital Dentistry?*

During the Canadian Dental Association's 37th Teaching Conference, keynote speaker, Mr Ted Ball, called for a stronger commitment from dentists in each province to justify the need for, and benefit of, a hospital program in dental education. Budget cuts proposed in recent legislation have made this objective one of the priorities of Dental Faculties in all provinces.

Presentations were delivered by: Dr. Kenneth Bentley, Montreal General Hospital, Dr. David Kenny, Hospital for Sick Children of Toronto, and Dr. Felicity Hardwick, University of Manitoba. The central theme of all the presentations was the value

of hospital experience for dental students.

Dr. Bentley discussed the program in place at McGill University and suggested it be used as a model for other Hospital Dentistry programs. He recommended that all hospital experiences occur within a 3-6 week timeframe. He suggested dental students should be involved in observation and active treatment in different areas of the hospital.

Dr. Kenny discussed the educational objectives of the Sick Children's Hospital in Toronto, which are designed to fulfill three main functions: firstly, a community service, secondly, a source for hospital resource and thirdly, an educational opportunity.

Dr. Felicity Hardwick presented the results of a recently completed University of Manitoba Hospital Dentistry Survey. Data covering the following issues was presented:

1. Classification of the program
2. Nature of the didactic component
3. Nature of the clinical component
4. Department responsible for administration

One accreditation objective is not being met by five of the ten hospital programs: five of the ten programs fail to allow dental students the opportunity to provide direct patient care, while participating in the management of the health and social problems of the hospital patient. It was found that in all programs, operative dentistry is the discipline most likely carried out in the hospital setting.

Thanks to Prof. Eunice Edgington, RDH, BScD, MA ed for providing a report.

Dental Hygiene Certification in Ontario — Facts You Should Know

Classes of Certificate

Effective January 1, 1994, all dental hygienists practising in Ontario who were previously licensed by the RCDS were entitled to receive a certificate of registration from the College of Dental Hygienists of Ontario (CDHO). This certificate may or may not have entitled you to practice depending on whether you chose to take an *active* or *inactive* certificate. Whatever your choice, the certificate must be renewed annually.

Every dental hygienist who was licensed and in good standing with the RCDS as of December 31, 1993 automatically became a holder of an active CDHO certificate. There are two classes of active certificates: 'General' and 'Specialty'. Only Expanded Duty hygienists received both and therefore would be entitled to call themselves Restorative Dental Hygienists.

Dental Hygienists who did not renew their license with the RCDS by December 31, 1993 have the option of obtaining an 'Inactive' CDHO certificate. An Inactive Certificate ensures you remain on the mailing list, and although you will not be entitled to practice, you will receive all information mailings thus allowing you to remain current with the profession.

Holders of an 'Inactive' certificate are entitled to move to an active class, although certain conditions apply — eg. you must have practiced for at least 500 hours in the previous three years or have taken a refresher course within the past 15 months.

Dental Hygienists who are not practicing as of December 31, 1993 and who chose not to take an

'Inactive' certificate will be kept on the CDHO records for two years as certified but unpaid. If by December 31, 1995 you have not chosen to take an 'Inactive' or one of the two active certificates, your certification will automatically be rescinded. Should this occur you will be unable to practice again in Ontario without recertifying — ie, rewriting the certification examinations, or such other terms, conditions or limitations as the Registration Committee may impose.

Protected Titles

You should know that the new Dental Hygiene Act says the following (in section 9):

"No person other than a member shall use the title 'Dental Hygienist', a variation or abbreviation or an equivalent in another language."

'Member' here means a member of the College of Dental Hygienists of Ontario, ie, a person certified by the CDHO. Under the regulations that were proposed to the Ministry, there will be similar protection for the title 'Restorative Dental Hygienist'.

Authorized Acts

Under the new Regulated Health Professions Act (RHPA), it is potentially harmful acts and procedures which are 'authorized', and professionals must be 'certified' in order to legally perform these acts. Thus, to quote a Ministry review of the legislation, "the acts are licensed, not the professional person. Authorized (licensed) (controlled) acts may be performed only by qualified health professionals authorized by their Professional Act to perform them."

CDHO Officially Opens New Facilities

November 25, 1993 marked the official opening of the College of Dental Hygienists of Ontario's (CDHO) new office facilities in Toronto. The new office is located at 69 Bloor St. E., Ste 300 in a recently renovated building owned and operated by the Institute of Chartered Accountants of Ontario (ICAO).

More than 100 friends and honoured guests joined members of the Transitional Council and staff to celebrate the opening. Representatives from the Canadian Dental Hygienists Association (CDHA),

the Ontario Dental Hygienists Association (ODHA), the Institute of Chartered Accountants of Ontario, the Ontario Ministry of Health, French Language Services and other Health Profession Regulatory Bodies, dentists and several dental hygienists were in attendance.

The opening of the new office facilities is the culmination of the work carried out by the Transitional Council over the past year and the efforts of many dental hygienists who ardently supported self-regulation.



*CDHO Official Opening: (l-r)
David Wilson, Executive
Director, Institute of Chartered
Accountants of Ontario (ICAO),
Ralph Neville, President, ICAO,
Lynda McKeown Mickelson,
Chair, Transitional Council,
Linda Strevens, Registrar,
College of Dental Hygienists of
Ontario*

CDHA Executive Council Meeting

CDHA Executive Council met in Winnipeg Jan. 21-23rd to conduct the annual environmental scan and association planning. In attendance were Fran Richardson Cotton, Maxine Borowko, Marnie Forgay and Lorraine Boomhour. Executive, with the assistance of CDHA staff Carol Matheson Worobey and Monique B. Rock, reviewed for the Board of Directors all CDHA Council's proposed activities and evaluations 1993-1995, and prepared the 1994/95 association budget.

While in Winnipeg, Executive was pleased to meet with Executive members of MDHA and DAAM to support common interests and legislative changes related to health care reform. Thanks are extended to Lorraine Glassford, MDHA President for organizing the discussion.

MOVING?

Please send your **new** address to:
Canadian Dental Hygienists Association
1018 Merivale Road, Suite 201
Ottawa, Ontario K1Z 6A5
*...And don't forget to include your
I.D. number!*



*Foyer of the building housing the College of
Dental Hygienists of Ontario in Toronto.*

Bloodborne Pathogens in the Health Care Setting: *Risk for Transmission*

Preface

The following Laboratory Centre for Disease Control, Health Canada (formerly Health and Welfare Canada) Report is presented for your information and consideration.

C.D.H.A.'s Practice and Regulation Council has inserted within the report *Advisory Opinion* to:

- further clarify statements and/or
- give a dental hygiene perspective and/or
- to emphasize significant issues.

The Canadian Dental Hygienists' Association is governed by a board of directors elected from across Canada, representative of its member population. Provincial constituent association members have had opportunity to comment and have shown their support for the *Advisory Opinion*.

I. Introduction

Concerns about the risk for transmission of hepatitis B and human immunodeficiency viruses in the health care setting led to a series of meetings, beginning in December 1991, organized by the Laboratory Centre for Disease Control, Health and Welfare Canada. **The purpose of these forums was to define areas of consensus among interested Canadian groups on issues related to transmission of bloodborne pathogens including hepatitis B virus (HBV) and the human immunodeficiency virus (HIV) from health care workers to patients/clients in a health care setting.** It was accepted that similar recommendations would apply to the testing, disclosure and management of patients. Although data are lacking on the risks of transmission of hepatitis C and non-HIV human lymphotropic viruses in the health care setting, the approach to other bloodborne viruses is expected to be similar to that for HBV and HIV.

The subject areas discussed at these meetings were as follows:

- HBV/HIV testing of health care workers
- Infection Control Guidelines
- Compliance with infection control procedures by health care workers
- Training of health care workers in principles and practices of infection control
- HIV- and HBV- positive health care workers and the risk of transmission in the health care setting
- Clinical management of health care workers pre- and post-exposure
- Assessment of HIV- and HBV- seropositive health care workers
- Assessment of invasive procedures performed by HBV- or HIV- infected health care workers
- Disclosure of an infected health care worker's status
- Public education

Participants represented a wide range of Canadian organizations concerned about health care, ethics in medicine, and Canadian law as it applies to such issues.

Statements and recommendations emerging from these discussions reflect a consensus based on current knowledge; however, a spectrum of opinion was expressed in most subject areas. These recommendations are subject to change through results of on-going study and research. This document is intended to serve as a guide for those who employ, educate, license and legislate health care workers in Canada.

In the following recommendations, "significant exposure" is defined as an injury during which one person's blood or other high-risk body fluid^b comes in contact with someone else's body cavity; subcutaneous tissue; or non-intact, chapped or abraded skin or mucous membrane. In this context, an instrument contaminated with the health care worker's blood or the dripping of blood may be the mechanism by which a significant exposure occurs; a glove tear or perforation by itself is not regarded as a significant exposure.

^a Participating organizations are listed in the appendix

^b Body fluids presenting risk for bloodborne-disease transmission are:

- | | |
|-----------------------|--------------------------|
| • Blood | • Pericardial Fluid |
| • Semen | • Amniotic Fluid |
| • Vaginal Secretions | • Peritoneal Fluid |
| • Cerebrospinal Fluid | • Other body fluids |
| • Synovial Fluid | containing visible blood |
| • Pleural Fluid | |

Advisory Opinion: *CDHA recognizes that saliva is not implicated in the transmission of HBV or HIV. However, because oral procedures may introduce visible or non-visible amounts of blood into the saliva, the saliva should be considered potentially infectious.*

II. HBV and HIV Testing of Health Care Workers

Statement

Programs for testing health care workers for HIV and HBV infection must be based on scientific principles, must consider ethical issues and legal precedents, and must be sensitive to the public needs. There is currently no legislation in Canada that specifically addresses the condition(s) under which testing of health care workers for HIV or HBV is warranted.

The participants of the meetings felt that a mandatory testing program for health care workers would not materially change the already extremely low risk for patients to acquire HIV or HBV infection in health care settings. In view of the risk, mandatory testing would be an unjustified measure that would violate the rights of individual privacy, and could result in acts of discrimination. The existence of such a testing program would likely have a major negative influence on the delivery of service and the training of health care workers in proper infection control practices because it would use scarce resources cur-

rently devoted to these high priority activities. There is also no scientific consensus on how often testing should be repeated if such a program were initiated.

Advisory Opinion: *Proposed mandatory testing has been demonstrated to have a strong adverse impact on health care access for certain communities. CDHA recognizes the high incidence of false positive results and the associated consequences, the expense involved in retesting, and the strong negative message relayed to the public.*

Recommendations

1. Mandatory testing of health care workers is not justified based on current scientific evidence.
2. Health care workers who have had a previous significant exposure or who have personal risk factors (e.g., high-risk sexual practices, IV drug use) should be encouraged to voluntarily seek HBV and HIV testing. Voluntary testing of health care workers who have no personal risk factors, based on perceived or potential occupational risk for transmitting HIV or HBV (e.g. persons performing invasive procedures), is not recommended.
3. Following a significant exposure to a patient's blood or other high-risk body fluid, voluntary testing of health care workers is recommended if:
 - a) the source patient is known to be infected with HIV or HBV;
 - b) epidemiological evidence suggests possible infection (e.g., high-risk sexual practices, IV drug use);
 - c) the source patient is unknown or is unable to consent to or refuses testing.

Advisory Opinion: *Additionally, CDHA recommends including the possible situation of: d) the serostatus of the source patient is unknown. Voluntary testing of the dental hygienist and the patient should follow a significant exposure to the patient's potentially infectious body fluids. Retesting of the dental hygienist should follow, on intervals as directed by the health department. The patient would only be notified to retest if the dental hygienist seroconverted.*

4. Health care workers have a moral and ethical obligation to be tested following a significant exposure by a patient to a health care worker's blood or high-risk body fluid if the health care worker's serological status is unknown. (See X, Recommendation 2)

III. Infection Control Guidelines

Statement

Universal Precautions were first introduced in Canada in 1987¹ in response to concern about occupational/nosocomial transmission of HIV/HBV from percutaneous exposures. Universal Precautions are specifically intended to prevent transmission of bloodborne pathogens from patients to health care workers; however, **they must be used in conjunction with traditional infection control systems for confirmed or suspected infections.**² Another established system, Body Substance Isolation³, replaces traditional isolation systems, with the exception of airborne infections. Neither Universal Precautions nor Body Substance Isolation recommend extra labelling of specimens or patients to identify them as requiring special care because of their

potential risk for transmitting infection.

The blurring of distinctions between Universal Precautions and Body Substance Isolation has led to an inconsistent application of terms and principles. Consistent use of both terms associated with promotion of a standard definition of practice would enhance understanding of the basic differences and improve the consistent application of appropriate terms and principles.

Recommendations

1. Universal Precautions should be regarded as the **minimum** standard of practice for preventing transmission of bloodborne pathogens in all health care settings. Universal Precautions must be clearly and consistently defined wherever they are described.
2. Current LCDC guidelines for Universal Precautions should be compiled in one document, revised and expanded in content. They should be based on current results of risk benefit studies and research findings and be organized in such a way as to facilitate adaptation to the specific needs of users. LCDC should assume a leadership role in the promotion of these guidelines to users, including professional associations, health organizations, health care facilities, and educators.
3. Health care settings (including institutions, private offices and clinics, and first-line responders) and mortuaries should have written documents that describe infection control strategies in their specific areas and outline procedures for situations where there is risk of significant exposure to blood or other high-risk body fluids. Such policies and procedures should be developed in consultation with appropriate experts.
4. Strategies for preventing transmission of bloodborne pathogens should be reviewed as new information becomes available and reevaluated as to their effectiveness.

Advisory Opinion: *CDHA strongly endorses the use of Universal Precautions in dental hygiene practice.*



“Health care workers who have had a previous significant exposure or who have personal risk factors... should be encouraged to voluntarily seek HBV and HIV testing.”

IV. Compliance with Infection Control Procedures by Health Care Workers

Statement

Currently available information indicates that the risk for transmitting disease with contaminated blood from an infected worker to a patient is very small when health care workers adhere to recommended infection control procedures. Mechanisms for assessing and improving compliance can be developed by implementation of standards against which compliance is measured. However, enforcement of compliance with these infection control procedures, including Universal Precautions, is difficult.

In health care facilities, internal quality assurance/risk management programs can be used to evaluate compliance with recommended infection control procedures. External accreditation councils can assist in this process. Although assessment of compliance is more difficult in independent settings, internal audits, clinical appraisals and on-site inspections exemplify methods that could be employed.

Recommendations

1. Standards for infection control practices in health care settings and mechanisms to implement and evaluate these standards should be developed through collaborative efforts by provincial health ministries, related professional associations and licensing bodies, and health care facilities.
2. Health Canada should contribute to this process by providing consistent and current national recommendations.
3. Suitable new technologies and methodologies should be promoted that enhance compliance with specific interventions such as disposal of non recapped needles through use of devices designed to reduce needlestick injuries.

Advisory Opinion: *CDHA recommends that dental hygienists keep their knowledge of bloodborne pathogens and infection control standards current and that educators revise and update curriculum as required.*

V. Training of Health Care Workers in Principles and Practices of Infection Control

Statement

The practice of infection control is integral to the delivery of safe health care. Teaching health care workers the principles of infection control is a necessary prerequisite to their understanding of, and compliance with, infection control practices.

Structured infection control training incorporated into the curricula of schools that provide education to prospective health care workers would facilitate the acquisition of knowledge and enhance understanding of basic principles at the entry-to-practice level. Instruction is also an essential component of orienting staff to a new workplace and in-service education should continue during employment. While the value of for-

mal training programs is recognized, the influence of role models on the practices of health care workers cannot be underestimated. Therefore, employees and medical staff in senior positions should be included in training programs. Further exploration is required to determine if a core curriculum can be developed that can be adapted and modified to the training needs of a particular practice setting.

Recommendations

1. Professional associations should be responsible for developing and promoting to their members continuing education programs in infection control.
2. Training in infection control should become a compulsory component of a health care worker's preparatory (pre-licensure) education and continuing education.
3. Training programs should be developed by associations, faculties or facilities and evaluated regularly to ensure that information is current and meets the changing needs of the health care worker. Continuing education programs should be based on a needs assessment.

Advisory Opinion: *CDHA recognizes its responsibility to promote and provide continuing education opportunities in principles and practices of infection control.*

VI. HIV- and HBV-Positive Health Care Workers and the Risk of Transmission in Health Care Settings

Statement

The risk of infection following exposure to blood contaminated with hepatitis B “e” antigen (HBeAg+) is estimated to be a 100 times greater than the risk of infection following exposure to blood contaminated with HIV. However, the risk for death is estimated to be similar following a single exposure to a sharp instrument contaminated with blood from an HBeAg+ or HIV-infected person.

A number of issues were discussed that could have a bearing on strategies aimed at reducing the risk of transmission of HIV and HBV in the health care setting. These included:

- i) A sub-population of individuals infected with HBV can be defined who appear to be more likely to transmit infection, e.g., persons who are HBeAg+.
- ii) HBV infection can be prevented by vaccination and/or hepatitis B immune globulin.
- iii) Psychosocial stigmata associated with HIV infection are several times greater than for HBV infection.
- iv) The willingness of persons infected with HIV to participate and comply with primary and secondary preventive strategies may be different from those infected with HBV. For example, it is likely that health care workers would more likely agree to HBV testing following a significant exposure than they would to HIV testing. Similarly, it is possible that they may be more willing to participate in pre-exposure HBV testing than they would with pre-exposure HIV testing.
- v) The clinical course of HIV infection, with respect to mental and physical deterioration, could increase the risk of occupational transmission of this virus. While this is potentially true for HBV infection, it is not the usual experience in clinical practice.

Advisory Opinion: *CDHA recommends ongoing evaluation of the dental hygienist's mental and physical condition as their disease progresses.*

Recommendation

When evaluating risk for transmission in the health care setting, and when planning strategies aimed at reducing the risk for transmission, similar considerations should apply to persons infected with HBV or HIV. However, the nature of specific preventive measures may differ (e.g., between HBeAg+ and HBeAg- individuals).

VII. Clinical Management of Health Care Workers Pre- and Post-Exposure

Statement

The effectiveness of hepatitis B vaccine in preventing HBV infection has been proven. Protecting health care workers from acute and chronic infection with this virus will further decrease the likelihood of health care worker to patient transmission in the future. Hepatitis B vaccination programs may be made more effective through the application of measures such as:

- i) offering vaccine to current staff;
- ii) making vaccination a condition of employment;
- iii) establishing a declination record for persons who refuse vaccination;
- iv) making vaccination mandatory before clinical training at schools providing education in health care services.

Surveillance for significant blood exposures of health care workers and patients would permit identification of persons infected as a result of the blood exposure and would permit counselling and the early management of their infection. Information collected by such a surveillance system would also be of value in better defining the risk for infection after a defined exposure.

A protocol for post-exposure management and follow-up of persons exposed to bloodborne pathogens should be generally applicable to all bloodborne pathogens, and be adaptable to a variety of health settings. Designated persons who are readily available should manage and follow-up exposed health care workers and patients according to current established protocols.⁴

Recommendations

1. All health care workers exposed to blood or blood products or at risk for occupational exposure to sharps injuries should be vaccinated against HBV. Within provinces, government, professional associations, institutions for training in health care disciplines, and health care facilities need to collaboratively establish programs for hepatitis B vaccination of these health care workers based on the demonstrated cost-effectiveness of these programs.

Advisory Opinion: *CDHA strongly recommends that all dental hygienists and dental hygiene students obtain HBV vaccination and maintain immunization.*

2. Campaigns aimed at promoting health and the personal benefits of reporting significant exposures should be developed to enhance participation in all health care settings and facilitate timely application of protocols. Professional associations, provincial governments, employees and educators should collaborate in the development of these campaigns.
3. All significant exposures should be reported through a proactive mechanism that:
 - a) is easy to access and is user-friendly;
 - b) assures confidentiality;
 - c) clearly and succinctly outlines information required from health care workers;

- d) provides for referral to appropriate experts;
- e) activates a protocol for follow-up that instills confidence in the exposed worker.

Advisory Opinion: *CDHA emphasizes the need to ensure confidentiality and recommends a "numbers only" record be kept of significant exposures.*

CDHA recommends that the protocol following a significant exposure include a consultative process readily available to the seropositive dental hygienist, through the primary care physician.

VIII. Assessment of HIV- and HBV-Seropositive Health Care Workers

Statement

Evaluation of health care workers who are infected with HIV or HBV will be enhanced if uniform criteria are used in a consistent manner maintaining confidentiality, and participation of appropriate organizations, licensing bodies, and public health officials is ensured, when necessary. The development of supportive review bodies within licensing and/or professional organizations with whom infected health care workers are willing to cooperate will assist in allaying public concern.

In developing the following recommendations, a greater spectrum of opinions was recognized compared with other subject areas discussed. The recommendations provide a framework for further discussions within provinces on the development of a uniform and consistent approach to the evaluation of seropositive health care workers.

Recommendations

1. Any health care worker with an infectious disease that could put a patient at risk is encouraged to voluntarily seek medical evaluation with respect to the potential for transmission of the infection to patients. Seeking medical evaluation is a fundamental ethical principle for health care workers infected with HIV or HBV.

Advisory Opinion: *Dental hygienists are encouraged to voluntarily seek ongoing comprehensive evaluation of their physical and mental limitations which may affect ability to practise and contribute to an increased risk to the client.*

2. Current guidelines and legislation dealing with confidentiality should be reinforced and followed. Reporting of seropositive health care workers must only be done within the requirements of current legislation.
3. Medical evaluation of an infected health care worker should be the responsibility of the health care worker's primary care physician. Primary care physicians who care for HIV- or HBV-infected health care workers are encouraged to seek advice on assessment of risk for transmission of infection in the health care setting through an established consultation mechanism.
4. A consultation mechanism that can be easily accessed by a primary care physician should be established, ideally in each province. This mechanism should ensure confidentiality and allow for input from public health, licensing bodies and/or professional associations, experts in infectious diseases and infection control, and others as judged appropriate to the situation. Participants in this process need not know the health care worker's identity. An existing provincial

reporting/consultation system may be adapted to serve as the consultation mechanism.

Advisory Opinion: *CDHA strongly endorses the above guidelines for the "Consultation Mechanism". The Profession of Dental Hygiene must have full and active representation in the development and operation of the "Consultation Mechanism".*

5. Criteria used to assess seropositive health care workers should include the medical evaluation (including mental condition), knowledge, application of infection control practices, and risk for injuries from sharp objects in the context of the individual's occupation.

Advisory Opinion: *A dental hygienist who meets physical, psychological and practice standards should be able to practise without restrictions.*

6. Supportive non-threatening programs through licensing and/or professional organizations should be developed to assist seropositive health care workers whose practices are modified because of their infection status. Career counselling and, if necessary, job retraining should be encouraged to promote the utilization of the health care worker's skills and knowledge.

Advisory Opinion: *CDHA recognizes that contributions can be made by dental hygienists whose practices have been modified by physical and mental limitations.*

IX. Assessment of Invasive Procedures Performed by HBV- or HIV-Infected Health Care Workers

Statement

Transmission of bloodborne pathogens from health care workers to patients has occurred during some invasive surgical and dental procedures. However, specific surgical procedures ("exposure-prone") that are associated with transmission of infection independent of the operator's technique, skill and medical status have not yet been well defined. In the absence of procedure-specific risk data, the concept of "exposure-prone" procedures is not useful for the development of strategies aimed at reducing transmission of bloodborne pathogens in health care settings.

Advisory Opinion: *CDHA recognizes the importance of, and supports a comprehensive approach to the assessment and management of seropositive dental hygienists' mental and physical status.*

Recommendation

High-risk practices and behaviours associated with invasive procedures need to be defined in specific health care settings, so that safer alternatives can be proposed to the health care worker and their implementation monitored. The identification of these practices and behaviours should consider the following:

- surgical techniques (e.g., manipulation of sharp objects without being able to see them clearly, digital palpation of sharp objects);
- environment (e.g., quality of equipment, level of assistance, physical setting);
- competency (e.g., fatigue, stress, level of training, experience and skill in relation to specific task, risk perception);
- exposure (e.g., potential for bleeding into a cavity, inadequate containment of bleeding);
- patient (e.g., uncooperative patient, adverse physical factors).

X. Disclosure of an Infected Health Care Worker's Status

Statement

Most contact between health care workers and patients does not involve the possibility of blood-to-blood contact and carries no risk for transmission of bloodborne pathogens. Current evidence suggests that risk of transmission of HIV and HBV from a serologically positive health care worker to a patient during an invasive procedure is extremely low.

As is the case for serological testing of patients and health care workers, disclosure of an infected person's test results involves many legal, ethical and personal considerations. An individual's right to know should be balanced with the potential harm caused if that knowledge is not kept confidential. A health care worker is under an ethical obligation to maintain confidentiality of patients' records, but the patient is under no similar ethical constraints. The decision to disclose or withhold the serological status of an infected health care worker is also complicated by the public's current perception of the risk of exposure. Disclosure of an infected health care worker's serological positive status could have a devastating impact on that person's ability to practice professionally, in spite of the extremely low risk from transmission of the infection from the health care worker to the patient.

Recommendations

- Routine disclosure of an infected health care worker's serological status is not justified.
- The patient should be notified when a significant exposure to an infected health care worker has occurred. There is no need to disclose the identity of the source of the exposure.

XI. Public Education

A strong, consistent, and repetitive message focusing on the factors related to transmission of bloodborne pathogens in the health care setting may enhance understanding of the relative risk and appropriate preventive measures for both the public and health care workers. Provincial health ministries, the Canadian Public Health Association, professional associations and the federal government share in the responsibility for assessing needs for information and for developing and disseminating appropriate messages.

Advisory Opinion: *CDHA recognizes its responsibility to promote and provide public education regarding the prevention and transmission of bloodborne diseases.*

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Appendix I: Participating Organizations

Alberta College of Physicians and Surgeons
 Alberta Dental Association
 Alberta Health
 Association des medecins microbiologistes infectiologues du Quebec
 Association des professionnels pour la prevention des infections
 Association of Canadian Faculties of Dentistry
 Association of Canadian Medical Colleges
 British Columbia Medical Association
 Canadian AIDS Society
 Canadian Association of Emergency Physicians
 Canadian Association of Interns and Residents
 Canadian Association of Medical Microbiologists
 Canadian Association of University Schools of Nursing
 Canadian Cancer society
 Canadian Centre for Occupational Health and Safety
 Canadian Council on Health Facilities Accreditation
 Canadian Dental Association
 Canadian Dental Hygienists Association
 Canadian Hemophilia Society
 Canadian Hospital Association
 Canadian Infectious Disease Society
 Canadian Intravenous Nurses' Association
 Canadian Medical Association
 Canadian Nurses' Association
 Canadian Orthopaedic Association
 Canadian Public Health Association
 Centre d'Etudes Sur le Sida
 College of Dental Surgeons of British Columbia
 College of Family Physicians of Canada
 College of Physicians and Surgeons of Ontario
 Community and Hospital Infection Control Association Canada
 Corporation professionnels des medecins du Quebec
 Department of Health, Newfoundland and Labrador
 Department of Health and Community Services, New Brunswick
 Department of Health and Social Services, Prince Edward Island
 Department of Health and Welfare
 Department of Justice (Federal)
 Federation des medecins omnipraticiens du Quebec
 Federation des medecins specialistes du Quebec
 Manitoba College of Physicians and Surgeons
 Manitoba Dental Association
 Manitoba Health
 Ministry of Health, Province of British Columbia
 National Advisory Committee on Aging
 National Association of Occupational Health Nurses
 Nova Scotia Dental Association
 Occupational Health and Safety Association
 Ontario Medical Association
 Ontario Ministry of Health
 Operating Room Nurses' Association of Canada
 Ordre des dentistes du quebec
 Patient Rights Association
 Professional Association of Residents and Interns of British Columbia
 Royal College of Dental Surgeons of Ontario
 Royal College of Physicians and Surgeons of Canada
 Saskatchewan Health
 Society of Obstetricians and Gynaecologists of Canada
 Toronto HIV Primary Care Physicians Group

INFECTION CONTROL SELF ASSESSMENT CHECKLIST

1. In my practice, I follow the Canadian Dental Association's guidelines for infection control procedures (as adopted by the CDHA June 1989).
2. I practice universal precautions by using the same infection control protocol for all clients.
3. When treating a client, my personal barriers consist of:
 - a) gloves
 - b) a mask
 - c) protective eyewear
 - d) a uniform or a lab coat
4. During procedures that splatter and produce aerosols (eg. ultrasonic scalers), I wear a mask that has a bacterial filtration efficiency (BFE) of 95% or more.
5. I avoid wearing jewelry, particularly rings, during treatment.
6. I remove my mask, rather than wearing it around my neck when I leave the operatory.
7. I wash my hands before gloving as well as after removing my gloves.
8. I change my gloves during an appointment, rather than washing them.
9. I flush all the water lines in my operatory before use in the morning and after each client.
10. I keep my client's dental file, charts and radiographs protected from contamination during treatment.
11. As an alternative to disinfection, I use operatory barriers to protect the equipment from contamination. (eg. covering the light handle, chair control switches, hoses, etc.)
12. I wear utility gloves when:
 - a) hand scrubbing instruments
 - b) cleaning and disinfecting my operatory
13. I use an ultrasonic cleaner rather than hand scrubbing my instruments.
14. I discard all used sharp items in a puncture resistant container.
15. I sterilize all handpieces or use high level disinfection, if they are non-sterilizable.
16. The sterilization equipment in my practice is checked with a biological monitor on a weekly basis.
17. In my practice, all contaminated items are disinfected before they are sent to the dental lab. (eg. impressions)
18. Before processing radiographs in an automatic film processor I:
 - a) disinfect the radiographs to decontaminate them
 - b) avoid touching the fabric light shield with contaminated items such as gloves or film packets.
19. I keep my vaccinations, particularly Hepatitis B up to date.
20. At the end of the work day, I change out of my work clothing/uniform before I go home.

Developed and submitted by
 Irene Ekberg, Instructor in the Dental Hygiene Program at SIAST, Regina, SK.

Report on Seniors' Dental Care

Past Experience and Future Challenges

By:
Donna Bowes, RDH

After attending the CDHA North American Research Conference held in Niagara Falls last October, Ms. Bowes says she found a significant amount of interest in the area of geriatric care being expressed by those in attendance. Consequently, when she returned home, she decided to offer CDHA members an opportunity to gain some insight on this topic from her own experiences. Although no 'formal' report summarizing the findings noted here was ever forwarded to the facilities involved, Ms. Bowes says that "some of the information gathered has been used in documents and reports that were forwarded to the Ministry of Health and the local Board of Health for Simcoe County."

The purpose of this report is to alert dental professionals to the future dental needs of our rapidly aging population and to perhaps assist those who are considering the provision of services to the elderly by outlining my personal experience.

Introduction

Our senior adult population generally have poorer dental health than younger groups. This is hardly surprising since they were raised in a time when the value of good dental health was not realized and the implications of an unhealthy dentition to general health was not widely understood. Preventive care was practically non-existent; curative care was relatively unsophisticated; treatment was often uncomfortable; modern procedures were unavailable and income rarely allowed for extra expenditures on dental care.

The prevalent attitude, still evident in some today, was that the loss of all teeth is an inevitable consequence of aging. Many are reluctant to spend scarce personal resources on what they perceive as a "losing cause".

Demographically seniors will increase from 11% of the population in 1980 to approximately 21% by the year 2030. In 1958 only 40% of seniors retained any natural teeth; by 2013 this statistic will rise to 76%.

In the very near future the Government of Ontario will be passing legislation on Long Term Care Reform. Included in this legislation will be Standards of Dental Services as well as Standards of Oral Care which each licensed facility in Ontario will have to meet in order to retain or attain a licence. The district health councils throughout Ontario will have compliance inspectors on staff to ensure standards are being met. It is uncertain at this time whether the Public Health Units will be tasked with the provision of some or all of the services. It may be that a combination of Public Health and private services will be required.

The focus of the Long Term Care Reform has been to maintain seniors in their own homes with enough support to ensure their health and safety. We can expect to see the numbers of homebound elderly increase dramatically over the next 20 years, thus increasing the need to provide a variety of dental treatment modalities.

Background/Experience

The institutionalized and homebound elderly are at an even greater disadvantage than their more active counterparts. Apart from the observations previously outlined, further barriers of mobility, income and lack of existing services greatly hamper access to dental care.

From 1986 to 1991, I was employed by the Simcoe County District Health Unit located in Barrie, Ontario. I was hired to organize a dental care service

for residents of Nursing Homes, Homes for the Aged and chronic wards on active treatment hospitals; a population of approximately 2000.

A Geriatric Dental Advisory Committee was formed which included Health Unit staff, representatives from the local dental society, denturists, nursing homes staff and staff working at homes for the aged. This committee met from April 1987 to March 1988 in order to develop and refine a program.

Numerous areas of concern were discussed and resolved including: mobility of residents, transportation problems, prioritization of treatment, funding of treatment, treatment delivery systems, referral mechanisms, orientation programs and all of the associated administrative tasks.

The resulting plan outlined services to be provided by each group:

Health Unit: screening, charting, referral, preventive services, education of caregivers, co-ordinating delivery and maintenance of portable equipment, follow-up of residents. (No fee involved.)

Dentists: examination, treatment planning (including cost estimates), curative dental treatment. (Fee for service.)

Denturists: examination, treatment planning, reline, repair and/or fabrication of complete dentures. (Fee for service.)

Nursing Homes/Homes for the Aged: on site staff assistance with program related activities, distribution and collection of consent forms and related paper work. (No fee involved.)

Implementation

The process began in the summer of 1988 with 1542 residents being screened by health unit staff. This screening included an oral assessment of each resident by a dental hygienist. With the aid of a dental assistant, complete dental charts and records were initiated on each resident and left at the facility. Referrals were sent to dentists (371) and denture therapists (98). The health unit staff was required to provide services to 1063 residents and a further 381 residents required no care.

In September 1989, residents were once again screened. Of those patients originally screened and referred, dentists had completed 87 cases (23%); denture therapists completed 22 cases (22%) and the health unit had completed 720 cases (68%).

Preventive services were delivered between January/March 1990, July/September 1990 and staff inservices were conducted between April/June 1990. The screening procedure was repeated from October/December 1990 and preventive services again followed in January/March 1991. Staff inservices were provided April/June 1991 following which, a survey was sent to each facility in order to evaluate the program from the perspective of the facilities.

Survey Results

Evaluations were divided into three categories according to facility type in order to compare similarities and differences in suggestions, problems and concerns. There appeared to be only minor differences between the facilities. The financial structure of the facility appeared to have little appreciable difference with regard to the evaluation of the program.

Part A: Preventive Services Provided

In general the facilities indicated a great deal of support and acceptance

of programs offered. It was felt that the preventive program satisfied most of the preventive needs of the residents. The facilities recommended that new residents be screened as soon after entry as possible. Therefore it was concluded that the health unit should provide screening, as needed, throughout the year.

From the perspective of the Health Unit staff, there was a great improvement in all aspects of the oral hygiene of the residents from 1988 to the 1991 report.

The staff inservice segment of the program proved to have difficulties. Although the information was appreciated and needed, presentations in person were 'hit and miss', due to the fact that staff members work shifts, are busy with routine assignments and cannot always be present at inservices. It was suggested that inservices be developed as 'self learning' modules to be left at the facility for a period of time. A staff member at each facility could be assigned to monitor the program ensuring that each staff member participates. Another suggestion to rectify this problem was the establishment of a 'lending library'.

Part B: Dentists' Services

This area was identified as the weak link in the provision of services to the residents. In many cases the dentists only provided emergency services (i.e., extractions). If further treatment was required, many dentists insisted on residents being transported to their offices. It was suggested that dentists seek further education in dealing with the handicapped, medically and mentally compromised patients in order to feel more comfortable with treatments. Education in the use of portable equipment to ensure that all treatment could be delivered on site was recommended. Many respondents commented that there was a definite need for a specially trained dental team to provide all services on site, free of charge. It was not difficult to have consent forms for examinations signed, but consent forms for treatment plans were more difficult to obtain. The Nursing Homes indicated financial consideration was the most common reason for lack of treatment for residents.

When residents were asked why they didn't consent to a recommended treatment plan, medical condition and/or perception that treatment would be unpleasant or traumatic, were the most common reasons given, followed by financial concerns.

When asked to suggest ways to overcome barriers to the provision of dental treatment services, respondents suggested, in order of frequency:

- 1) provision of cost free dental services
- 2) increasing public awareness of the importance of dental health throughout the life span
- 3) provision of all treatment services on site

Part C: Denture Therapy (Denturist Services)

Most of the facilities reported that a denturist provided services on site and that services were satisfactory. However the response rate to calls was slow and at times communication only involved residents. The staff at the facilities felt that because the residents can be confused, a staff member should be present when the client is informed of treatment needed and also when treatment is rendered.

Part D: Suggestions for Changes

The responses from the hospitals differed from the other facilities. Although Health Unit activities were delivered only on chronic wards, the staff rotated throughout the hospital. Staff inservices and information need to be delivered to all hospital staff, not just to staff on chronic wards on any particular day. It was suggested that treatment services should be available throughout the hospital to any long-term patient.

All respondents identified the need for on site treatment at little or no cost. The need to educate and provide dental personnel with the skills required to deal with the varieties and inconsistencies of behaviour, and physical conditions of the aged, was a frequent suggestion. In general, an

increased awareness of the importance of dental health and regular oral health care for the aged was identified as a critical aspect.

Recommendations

As a result of this survey a number of recommendations were made. Some of the recommendations were specific to the facilities themselves, some were directed to the Ontario government, and others were directed to dental professionals in general. The recommendations are:

- 1) Mandatory oral screenings for every new resident in a facility, and then on an annual basis thereafter.
- 2) Mandatory preventive services as needed for all residents of Collective Living Centres.
- 3) Mandatory denture identification upon fabrication of complete and/or partial dentures.
- 4) Increase access to staff inservices for all caregivers.
- 5) Mandatory written mouthcare policies and procedures for every licensed facility.
- 6) Distribution of approved mouthcare items only, by the Ministry of Health Pharmacy.
- 7) Teaching of oral health care procedures to all health care students by dental professionals.
- 8) Inclusion of gerontology studies in educational curriculum of all health professions.
- 9) Inclusion of geriatric dentistry in curriculum for all dental hygiene, dentistry and denture therapy students.
- 10) Increased access to continuing education courses in geriatric dentistry for all practicing dental professionals.
- 11) The development of a government funded dental program for seniors in need.
- 12) Increased public awareness of the importance of oral health throughout life by the dental community.

Conclusion

These ambitious recommendations encompass many areas and involve a variety of groups, professions and government agencies. The dental community is very much admired for the leadership role it has taken in the area of preventive oral health care. Who better than dental hygienists, to lead this quest on behalf of older adults?



DONNA BOWES, RDH

Donna Bowes graduated in 1980 with a Diploma in Dental Hygiene from Algonquin College. In 1989 she graduated from Georgian College with a Certificate in Gerontology. Being married to an officer in the Canadian Armed Forces, she has had the opportunity to be employed in numerous practice settings across Canada and in Lahr, West Germany first as a dental assistant and then in an expanded function role and finally as a dental hygienist. She has experienced private practice, specialty, institutional, military and public health settings. She is currently serving as a professional member appointed to the Transitional Council of the College of Dental Hygienists of Ontario.

1994 — A Year of Oral Health

April 7, 1994 — World Health Day

This year World Health Day is especially important to the dental hygiene profession because of its focus on Oral Health. Information kits have been developed and are being distributed by the Canadian Society for International Health, 902-170 Laurier Ave. W., Ottawa, ON, K1Z 5V5, Attn: Mary Bridgeo. The materials include a press kit and poster, a resource booklet, and a set of oral health success stories.



number of materials to promote the oral health theme for 1994's World Health Day and it is encouraging health professionals to plan activities that will emphasize Oral Health during their national or international meetings, or in any other health projects they may be developing during 1994. Local dental hygiene societies may opt to host joint activities with neighbouring communities to promote oral health awareness using the CSHI materials during National Dental Hygiene Campaign (October 16-22) or celebrate with activities and projects on World Health Day, April 7th.

History

In 1990, the International Dental Federation (FDI) observer at the WHO Regional Committee for South East Asia suggested that WHO celebrate a year of oral health. That request was transmitted to WHO's Headquarters in Geneva and it was agreed that WHO would adopt oral health for the theme for World Health Day in 1994. Although WHO does not have a policy of dedicating a year to any theme, it encouraged the whole dental profession to celebrate 1994 as a Year of Oral Health. Subsequently, the four major international dental bodies: the International Dental Federation (FDI), the International Association for Dental Research (IADR), the International Federation of Dental Hygienists (IFDH) and the International Federation of Dental Education (IFDE) agreed to work together to develop activities to celebrate the year.

Encouraging Active Participation

The Canadian Society for International Health has developed a

Towards a Better Oral Health Future

*A paper prepared by the
WHO Oral Health Program*

Background

As a result of responses, and in relation to the initiative of the International Association for Dental Research (IADR) to develop an International Leadership Forum to coordinate the interest in the Year of Oral Health, a paper entitled "Towards a Better Oral Health Future" was developed. This document formed the basis of discussions at several meetings held in Chicago last March during the International Association for Dental Research Annual Sessions.

The paper highlights the major developments that have occurred in oral health in the past half century — from the promotion of toothbrushing, to the limiting of sugar consumption, to the use of fluorides in the prevention of dental caries. It notes the significant changes in the education of all dental professionals. Educational programs have passed through stages of a broadening biological base — from routine conservative restorative, surgical and medical procedures — to massive improvements in dental materials and equipment and an increasing emphasis on prevention (risk assessment, tissue conservation and the preservation of a functional dentition) thus reorienting dental education to an even broader approach.

According to the paper, the dental profession as a whole has been responsible for all the advances witnessed in dentistry over the past half century. In addition it acknowledges the contributions of other health professions in supporting, enabling and participating in the advancement of oral health status of communities. It further notes that the symbiosis of industry with the dental and other health professions, in all areas of the development of better oral health and care, has also been an important part of the success story.



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"A Question of Conscience — A Matter of Choice"



Pamela Wallin, broadcast journalist and co-anchor of CBC's Prime Time News, will be the opening speaker.



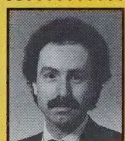
Lynn Guest, RDH, BHE, (MSc candidate) Ms. Guest, a 1975 graduate of the University of British Columbia Dental Hygiene program, earned a BHE, majoring in Nutrition while working in private practice from 1975-1980. Since 1980, she has worked as a community dental hygienist in the Fraser Valley Region of B.C. In 1992 she enrolled in the MSc (Dental Science) program at U.B.C. Her thesis will explore the quality of life issues as they relate to older adults and oral health. She is currently acting as the Manager of Dental Programs for the province. Ms. Guest's focus is on standards of care and access to care for residents of extended care facilities and the role of the community health dental hygienist in relation to the individuals and agencies involved in providing care in "new settings".



Michael Rachlis, MD, MSc, FRCPC will examine the role of the dental hygienist in forging new relationships that can push the political agenda toward changing Canada's health care delivery system.



Maxine Borowko, RDH, SDT, Cert VIT Ed Ms. Borowko earned both her diploma in Dental Therapy (1974) and diploma in Dental Hygiene (1984) from SIAT in Regina, and in 1985 a certificate in Vocational Technical Education from the University of Regina. She has extensive clinical, educational and administrative Dental Hygiene practice experience in both private and public health sectors. She has provided care to intermediate and extended care residents in Long Term Care Hospitals and is currently working in Community Health providing services to the Mentally Challenged and in private practice. Her professional goal is to work toward establishing the recognition of dental hygienists as members of a Multi-Disciplinary Health Care Team.



Gary Chiodo, DMD will describe three cases that will show how the actions of Dental Hygienists can reflect the central values of the profession.



Jennifer Thomas, RDH, BA, MEd Upon her arrival from Great Britain in 1972, Ms. Thomas earned a BA from Carleton University and has recently completed a MEd from the University of Ottawa. In her current capacity as a Preventive Periodontal Consultant with Experdent Consultants Inc., she travels across North America assisting dental offices in setting up efficient and effective periodontal programs. She has lectured extensively at various Dental workshops and conventions, produced a videotape on oral health care directed to nursing in-service, the "Senior Smiles" training manual, and a Charting Booklet for dental hygienists to help alleviate the ethical dilemma of inadequate record taking.



Brent Cotter, Deputy Minister of Justice and Deputy Attorney General — Province of Saskatchewan will present a model for solving possible ethical dilemmas faced by dental hygienists.



Marg Wilson, RDH, BEd Marg Wilson earned both her Diploma in Dental Hygiene (1971) and her Bachelor of Education Degree (1981) at the University of Alberta. She has practised clinically in Public Health, General Practice and currently works part time in a Periodontic Specialty Practice. Marg is also a Clinical Associate Professor at the Faculty of Dentistry, University of Alberta. She instructs clinically and coordinates and lectures in several courses for both dental hygiene and dentistry students. Marg has been involved in teaching ethics since 1987. Throughout her professional life, Marg has been an active and involved member of her Professional Associations, serving on Executives locally, provincially and nationally. She is presently Chairperson for the CDHA's Professional Development Council.



Toby Segal, RDH, BS will describe the results of the California HMPP Project in which Dental Hygienists offered increased access to oral health care to underserved segments of the population.

• S C H E D U L E •

Friday, June 17, 1994

1:00 pm

Opening Greetings

1:30 - 2:30 pm

Guest Speaker — Pamela Wallin

2:45 - 5:15 pm

Guest Speaker — Dr. Michael Rachlis

"Saving Medicare — The Power and The Glory"

Class Reunions

Saturday, June 18, 1994

8:30 - 9:45 am

Guest Speaker — Mr. Brent Cotter

"Dental Hygiene & Health Care — Coming to Terms with the Ethical and Moral Dilemmas"

9:45 - 11:00 am

Guest Speaker — Dr. Gary Chiodo

"Applied Ethics in Dental Hygiene Practice — Voicing Our Value"

11:15 am - 1:00 pm

Ms. Marg Wilson

Ms. Jenny Thomas

"Nobody Ever Told Me There Would Be Days Like These — A Decision Making Process for the 90's"

1:00 pm

Lunch Buffet

1:30 - 5:00 pm

Commercial Exhibits, Poster Sessions, Table Clinics

6:30 pm

Evening Social at the Western Development Museum — Dinner and Entertainment

Sunday, June 19, 1994

8:00 - 9:00 am

Ms. Maxine Borowko

Ms. Lynn Guest

"New Clients/New Settings/New Questions" (Ethical dilemmas to consider when meeting the needs of special clients groups)

9:00 - 10:15 am

Panel I

Moderator — Ms. Marnie Forgay

"Can Ethics Be Learned?"

10:30 - 11:45 am

Panel II

Moderator — Ms. Jenny Thomas

"Ethics of Access to Care"

11:45 am - 12:45 pm

Brunch

12:45 - 2:00 pm

Ms. Tobelle (Toby) Segal

"The California Vision" (or How a Peace Time Manoeuvre Turned Into a War)

2:00 - 3:00 pm

Panel III

Moderator — Ms. Sheryl Feller

"New Practice Arrangements"

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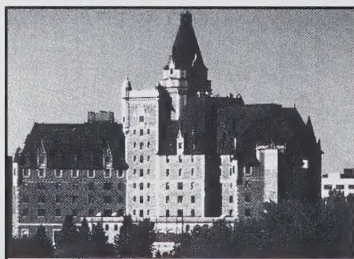
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The Communication Imperative: A Critical Thinking Paradigm

By:
Eunice M. Edgington,
Dip DH, BScD, MA(Ed)

The communication imperative is a recognition of the fact that the interpersonal relationship between the health care provider and the client is as fundamental to building and maintaining a practice as is clinical skill.¹ At the University of Alberta we have introduced a Critical Thinking Module in an attempt to focus on this relationship and to encourage students to examine their beliefs and attitudes in a new way. This article will examine some of the background to this decision as well as look at the course itself.

Introduction

An apparent trend in our current economy, is that dental practices are experiencing a reduced clientele and clients who continue to seek oral health care are more selective in their choice and frequency of dental services.² This selectivity is the result of many factors, but it is important for health care personnel to be aware that how a client chooses to spend money is not always a condition of need, but is often influenced by persuasive and sophisticated marketing technology.³

We are continually bombarded with media messages offering personal satisfaction and enhanced life styles.³ Dentistry is in competition with this type of marketing for the consumer's dollar. We must be able to deliver the oral health care message more effectively in order to remain productive.⁴ This does not mean that we become slick operators, but it does imply being willing to spend the time and effort needed to work with our clients in setting priorities for treatment goals that will promote optimal oral health.⁵

Within a multicultural society, many of our clients may not subscribe to North American health care beliefs and/or standards. Professionals often impose their health standards on others without acknowledging the cultural differences.⁶ By respecting the differences and working with these clients oral health care providers may be more successful in reinforcing the health benefits of regular oral health care.⁶ One way of achieving a better awareness and understanding between the clients and the health care worker is through mutual cooperation and enhanced interpersonal communication.⁷

All of this — a changing economy, competition for scarce resources and our complex society — means that more value must be put on the development of interpersonal skills. In the past, technical skill was the primary focus of oral health care education, perhaps because of its tangible benefits. However, the importance of good interpersonal skills is well documented in dental literature and although an intangible benefit, has far reaching influences on the oral health care practices of our clients and on the maintenance and sustenance of a successful dental practice.^{1,4,6-9}



EUNICE EDGINGTON,
DIP DH, BScD, MA(Ed)

Literature Review

A literature review was done to investigate the impact that interpersonal skills play in a client's decision to select and remain with a dental practice. The following questions were the primary focus of this review.

1. What marketing factors and personal attributes are considered by clients when selecting a dental practice?
2. What keeps clients from maintaining regular visits to a dental practice?
3. What attributes are important for client compliance with professional recommendations?

The intent of this review was to find evidence of the importance of interpersonal skills in oral health care delivery, as perceived by the client. It is not within the scope of this paper to discuss at length all the factors present in each study. For the sake of brevity, a summary of the specific factors supporting the hypothesis is included.

1. What marketing factors and personal attributes are considered by clients when selecting a dental practice?
 - Twelve marketing strategies used in dentistry were rated by clients; of these, the respondents selected: quality of care, personal attention and communication as having the greatest influence on choosing a practice.^{9,10}
 - Another study revealed that a dentist's reputation was the most significant factor considered when selecting a new practice. Reputation was defined in terms of the dentist's interpersonal behaviour.¹¹
 - A survey of clients of 21 practices showed that the primary reasons given for choosing a practice included perceived quality of care, a dentist who is willing to discuss treatment and alternatives, a practice where emphasis is placed on preventive dentistry and where there is sensitivity to the treatment of children.⁹
2. What keeps people from maintaining regular visits to a dental practice?
 - A study was administered which listed five possible factors which keep people from seeking regular oral health care: one factor was that respondents felt that dental care was not necessary.⁹

The implication in this study was that clients did not understand the value of oral health care. Perhaps this was due to inadequate oral health education and communication by the oral health care providers.

- An investigation of why orthodontic patients terminated treatment revealed that the respondents felt that a lack of motivation, insufficient information about treatment and lack of communication between orthodontist and client were the primary reasons.¹²

This clearly indicates that maintaining a relationship of mutual understanding and cooperation with the client is fundamental to achieving long-term oral health goals. It further emphasizes that an interpersonal relationship is a continuum rather than a one shot deal. (ie, tell them all they need to know on the first appointment and very little thereafter).

3. What attributes are important for client compliance with professional recommendations?

- Current literature reveals how the initial perception of compliance implied a provider-orientated rather than a client-oriented frame of reference. Weinstein, Getz and Milgrom suggest an imposed standard, rather than a mutual agreement achieved through open dialogue between the professional and the client.⁵

In summary, a mutual participation model is recommended as more effective in establishing long-term oral health care practices with clients.^{4,5}

It is evident that more clients remain committed to home care regimes for longer periods of time, when the professional works with them to improve already existing self-care patterns, rather than by imposing regimes that the client is unfamiliar with and that are valued only by the professional.⁴

Studies, along with many text books on health communication, emphasize the importance of interpersonal skills in health care delivery.^{1,5,8-13} It is frequently stated that a client's primary reason for selecting and remaining with a dental practice are the interpersonal skills of the dentist. Since a client has no real way of evaluating a dentist's clinical skills, proficiency to the technical aspects is attributed according to his/her interpersonal experience. One could extrapolate from the literature that the importance of interpersonal skills is similar and perhaps of even greater importance in dental hygiene practice.

Over the past decade communication has been given more emphasis in dental hygiene education.^{4,5} However, achieving proficiency in interpersonal skills through a communication curriculum may be beyond the scope of dental hygiene education. Certainly, the complexity of the subject, together with the heterogeneous nature of the classes and the length of the programs, makes interpersonal skill training a monumental challenge.

How Communication Skills Are Acquired

Effective communication is an intimate weave of complex variables including attitudes, feelings, knowledge, socialization, culture, age, status and language. It is a dynamic and ever changing phenomenon.^{4,14,17}

We learn how to communicate within our socialization process by imitating our role models: we shape and reshape our responses according to the reaction from others. This is often based on assumptions we have formed about life from our early conditioning. The education process provides little opportunity for us to examine how our personal assumptions and beliefs effect our reactions to others; in fact, most of our communication is learned by trial and error.⁴

Interpersonal skill training can provide us with many alternative ways of interrelating. Interpersonal skills include: techniques for handling conflict, models for facilitating, questioning and confronting and active listening techniques. Knowledge and awareness are indeed important aspects of improving our interpersonal relationships, but making them a part of our daily response patterns requires a good deal of energy and awareness.¹⁴

Subjective Emotional Responses

We are taught during our dental hygiene education to modify our subjective responses in the interest of client care.¹⁴ In fact, much of our personal behavior is subjected to the professional discipline: we undergo a rigorous socialization process which shapes our relationships with our clients.¹⁴

However, little is done to find out how we think and feel when we begin our dental hygiene education: any strongly-held ideas or feelings that we do hold can remain masked by the proscribed and prescribed behaviors of our profession. In emotionally charged situations our subjective reactions can surface. If we do not acknowledge and understand our reactions, they may interfere with patient care and affect our relationship with our clients.¹⁴

Alcoholism is a case in point. We may be taught that alcoholism is a disease, but we may believe that it is a controllable habit; it may be this subjective belief that is transmitted to an alcoholic client rather than what we have been taught. Strongly-held emotional and personal beliefs will be evident in our expression, our tone of voice and in many of our non-verbal behaviours.¹⁴ Thus supportive words without supportive attitudes will sound insincere, and will impact on our relationship with the client.¹⁴

Stewart and Rotor claimed that "unless we allow ourselves to reach inward without fear of losing reality, the patient will not sense a connectedness in the relationship and will not risk the intimacy that is required in a healing relationship."¹⁴ Professionals who have not learned to deal with their subjective feelings and emotions may react to emotionally charged situations in different ways, such as avoiding the client, overtreating the problem, acting with hostility or by rejecting the client.¹⁴

The dilemma of how educators can get students to recognize their personal beliefs and feelings about certain situations and/or clients without alienating the student had to be addressed. As clinical educators, we are aware of students' subjective reaction to certain clients. When confronted with these behaviors, the student often reacts with denial and disbelief. Students must be allowed to recognize their personal behaviors without fear of judgement or failure. This means developing a format that encourages students to share possible responses to specific situations with other class members, in a friendly open atmosphere. This would enable students to evaluate the impact of a variety of responses, and to share reactions and responses with other students thus enabling them to understand the uniqueness of possible personal response options.

The Dental Hygiene School at the University of Alberta developed a Critical Thinking Module that encompassed most of what was felt was needed to get the students to address some personal beliefs and assumptions evident in their behavior in clinic. It was believed that this was a good first step in interpersonal skill enhancement given the breadth of the subject and the time available for this program.

Enhancing Interpersonal Skills Through Critical Thinking

Critical thinking can be defined as the process of uncovering and analysing the assumptions that influence our beliefs and actions. It involves becoming aware of how we make assumptions, identifying implicit and explicit ones and assessing their accuracy and validity.¹⁵ We have to ask ourselves if our assumptions make sense in our current reality as we understand and live it.¹⁵

For example, the word *professional* can have different meanings for different people, depending on the culture, the era of professional education and the institute of study. Dental hygiene education in the 1950's had different prescribed and proscribed behaviors assigned to the image of *professional* than are evident today. The description of an ideal dental hygienist in 1950 included the following: "Someone with the ability to execute orders without eternally asking 'why'."¹⁶ This was a common perception during the pre-feminist era when women were selected for careers such as dental hygiene, based on their gender. It was considered more *professional* for women to be passive and take orders rather than to ask questions.¹⁶ Today, an inquiring mind and a curious intelligence are valued and necessary qualities in order for a dental hygiene student to succeed.¹⁵ Qualities such as these are no longer gender-based and both men and women enjoy equal opportunity for success in dental hygiene.

In dental hygiene instruction, it is important to realize that many differences are evident among the instructors, because they are from various educational institutes, have different work experiences and graduated at different times. As a result, instructors may subscribe to a variety of ideals of *professionalism*, and their evaluation of students may be based on the conditioned behaviors of their education and experience.

This can seem contradictory to the students who often complain that they are confused when one instructor tells them one thing and another instructor tells them another.

A Critical Thinking Module was designed and scenarios were presented using actual clinical situations. The situations depicted interactions of miscommunication between client, student and/or instructors. Confidentiality and anonymity of the people involved was respected. Students were instructed to analyze each scenario from an objective perspective and not to judge the rightness or wrongness of each interaction. They were further instructed to identify the possible assumptions made by each person in the scenario, and to write a different perspective for each interaction. Following this exercise each student shared his/her perspective with the class.

It became evident that many different perspectives existed among the students as well. Students shared many creative ways of handling the situations presented. The interaction and enthusiastic discussion was at a very intense level.

Observation and feedback confirmed the following points. Students liked the format as it allowed them to discover, in a positive way, the many different perspectives that are possible in a given situation. They realized that they should not jump to conclusions about others, when involved in a difficult interaction. As a result of these exercises, the students also expressed an increased awareness of, and respect for the differences among instructors. They also expressed the realization that instruction can be situational and specific to a certain task, and not necessarily applicable in all situations. The complexity of the student,

client, instructor triad was also discussed and students expressed a new awareness of their responsibility to the harmony of this relationship. Students also discovered that they should not prejudge their clients' responses and that further probing is often necessary to confirm whether assumptions are valid.

Examples of a few of the situations involving clients follow:

- Clients who appear to be interested in everything you say, but do not put any of what you have said into practice.
- Clients who appear to be unresponsive but put everything into practice.
- Clients who are of a different culture and may have never seen a modern dental office.
- Clients who may have a different health perception than we do in N. America.
- Clients who use compliments such as "You are the first hygienist who has ever told me that"
- Clients who say "No one has ever cleaned my teeth that well before"

This Critical Thinking Module clearly has helped our students to become more aware of the complexity of the student-client-instructor relationship. Partly as a result of this success, a Critical Thinking Workshop was presented to the clinical instructors at the University of Alberta, as part of a staff development program. The goal of the workshop was to increase communication awareness and translate it into a more positive clinical experience for everyone.

Scenarios were provided by the students depicting miscommunication situations that had occurred in clinic. The instructors were made aware of the students perspective and were asked to look at each scenario not only from this point of view, but from the view of all those involved in the interaction.

The instructors collaborated to formulate more positive solutions to the difficult situations presented. The recommendations and suggestions will be summarized and given to all instructors for future reference.

This workshop has provided us with the foundation for a more positive interaction with the students. The instructors felt that the format was very constructive in terms of identifying problems and understanding how we impact on the student. To quote one instructor "It was better than discussing individual situations in isolation from the students' perspective." It was generally agreed that the input of each instructor was valuable in providing a different but plausible perspective to each scenario. This process allowed us to look at ourselves without feeling singled out and provided many different and positive alternatives to difficult situations.

Summary

- Interpersonal skills are fundamental to building and sustaining a productive dental practice
- Communication is imperative. Many studies identify communication as a significant factor in clients' decisions when selecting a dentist and continuing oral health care with that practice.
- Communication involves becoming aware of our subjective emotional nature and learning how to use it to show compassion
- Communication involves critical thinking, which is a process of identifying and assessing the assumptions which shape our beliefs and actions.

- Critical thinking is a useful mechanism to get students to examine the assumptions that motivate their behavior and so is a first step to enhancing their interpersonal skills.
- Critical thinking is a productive staff development exercise to improve interpersonal relations in clinical dental hygiene education.

Conclusion

The objectives of this paper were to confirm that interpersonal skills are fundamental to dental hygiene practice and to support critical thinking as a first step in enhancing interpersonal skills.

A communication and critical thinking component has been included in our clinical evaluation of patient management at the University of Alberta Dental Hygiene Faculty. A Critical Thinking Module has been included in our curriculum. Analysing scenarios depicting aspects of clinical education, as well as situations of patient management, appears to increase problem solving abilities and enhance the depth of interpersonal interaction. It also increased awareness of alternate ways of interrelating.

This Critical Thinking Module has also provided a base for professional development. Students have provided scenarios for analysis by the instructors. By analysing these scenarios objectively, instructors have become more aware of the impact of their communication on the student. Through the sharing of individual ideas, more positive approaches have been discussed to enhance our teaching opportunity with our students. Over the long-term it is anticipated that this will create a more collaborative learning environment where the student feels like a partner in the education process.

Further development and study will be needed to assess the long-term effects of the Critical Thinking Module and the Critical Thinking Workshop. However, initial results are very encouraging.

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Saskatchewan-born, Ms. Edgington graduated from the University of Toronto in 1967 (Dip Hyg) and after 13 years of private practice, earned a BScD from her alma mater. While teaching at Durham College in Oshawa, Ontario (1982-88) she earned a MA(ed) from Central Michigan University. Presently, as an Assistant Professor at the University of Alberta, she supervises Hospital Dentistry and Special Needs. Her keen interest in Communication extends into her leisure time, as well as interests in reading, physical fitness, hockey-Mom activities and travelling.

IMPORTANT DATES TO REMEMBER

1994

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| April 7 | World Health Day |
| April 21, 22 | ODHA Spring Meeting, Toronto, ON |
| June 17-19 | CDHA Annual Professional Conference
<i>Sharpen Your Professional Edge:
A Question of Conscience—
A Matter of Choice</i>
Saskatoon, SK |
| July 8-10 | World Conference for Oral Health
Tokyo, Japan |
| August 5-7 | ADHA Research Conference
Minneapolis, MN |

1995

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| June 16-18 | CDHA Professional Conference
Halifax, NS |
| Nov. 23-25 | IFDH Symposium, Tokyo, Japan |

Book Review

BOOK REVIEW

Ethical Questions in Dentistry

James T. Rule, Robert M. Veatch;
1993; Quintessence Publishing Co. Inc.,
551 North Kimberly Dr.,
Carol Stream, Illinois, USA 60188;
indexed, 282 pages

Reviewed by: Carole K. Ono, RDH, BA, MEd,
Coordinator, Dental Hygiene Program,
Niagara College, Welland, ON

Over the decade, there has been a greater focus on ethics, by the dental professions. This has been reflected in the professional literature, activities of professional organizations, topics of professional conferences and curriculum changes in dental and dental hygiene programs. However, the lack of a comprehensive coverage of ethics as related to the dental profession in the form of a textbook created a void. This text now fills that void.

The combined efforts of the two authors: a dentist and an ethicist provide a unique blend of ethical theory and principles with cases of ethical problems faced by dental personnel. The text is written in a style that is easily understood and does not require the reader to have a grounding in philosophy.

The book is organized into three major sections. Part I guides the reader through an overview of ethics in dentistry, basic ethical theory and principles, and a format for resolving ethical questions. This section is succinct. It enables the reader to understand the principles of ethics and to apply these principles in a framework to resolve ethical dilemmas. The protocol for ethical decision-making leads the reader through a step-by-step analysis of determining the alternatives, the ethical considerations, the considered judgments of others and ranking the alternatives. This process of ethical case analysis is illustrated using a case study.

Part II and Part III consist of ethical analysis of 111 cases based on actual events. The cases were contributed by general practitioners, specialists, dental hygienists and educators. The cases presented illustrate the ethical principles of beneficence (acting to benefit the patient), non-maleficence (avoiding harm), patient autonomy, informed consent, veracity (truth telling), fidelity (obligations of trust and confidentiality), and justice. The ethical issues presented by the case studies cover a wide range of ethical dilemmas faced daily by dental personnel. Part III includes discussion of special topics such as third-party payment, dental research, AIDS, and cases involving incompetent, dishonest and impaired dentists. Of

special interest to educators, Part III also includes ethical dilemmas encountered in dental educational settings.

The text is well organized and the detailed table of contents provides a clear preview of the contents of each section and chapter. The headings, however, are unsettling to the eye with the varied types of large bold, smaller bold and italicized print. Judicious use of spacing may facilitate the visual flow from heading to heading.

A noted deficiency of this text is the absence of a section dealing with ethical issues related to the interrelationships between dentists, dental hygienists and dental assistants. Perhaps the authors would consider this topic for inclusion in the next edition.

Although the text has been directed towards dentists and dental students and the case studies with the exception of a few, are related to dentists, the book has value for practising dental hygienists and dental hygiene students. It provides all readers with the basic principles of ethics, and useful guidelines for ethical reasoning and resolution of ethical problems. Greater

appeal to the dental hygiene audience however, could be made by including many more ethical issues related to dental hygiene.

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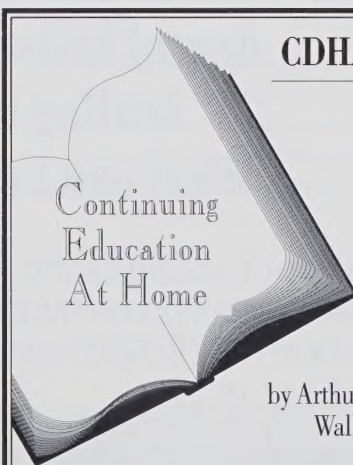
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CDHA's Book of the Month Suggestions

March:

Sexual Harassment:

A Guide for Understanding and Prevention

by Dr. Arjun P. Aggarwal

Butterworths, Toronto, ON 129 pages, 1992

ISBN 0-40990852-5

April:

Health Care Ethics

by Arthur H. Parsons, MD and Patricia Houlihan Parsons

Wall & Emerson, Inc., Toronto, ON 194 pages, 1992

ISBN 1-895131-08-1

Both of these books are available from the Canadian Hospital Association,
17 York St., Suite 100, Ottawa, ON K1N 9J6 (613) 238-8005

Periodontal Disease in the Life Stages of Women

Reviewed by:
Carol Barr Overholt, RDH

By:
Susan Folkers DDS
Franklin Weine DDS MSD
Donald Weissman DDS
Journal: Oral Health Oct/93

This literature review article indicates that research has determined that certain periodontal diseases have a predilection for women.

The paper reviews the periodontal conditions that may be correlated to the life stages of women: puberty, young adulthood, adulthood, pregnancy (and oral contraceptive use) and the post-menopausal years.

The incidence of pubertal women affected with Juvenile Periodontitis was 0.1-0.4% of the available population; a ratio of 3:2 (to men). The disease occurred more frequently in Black clients and the literature indicated a possibility of disease transmission via a genetic link.

Studies cited also supported a possible hormonal/genetic influence on the etiology of Rapidly Progressive Periodontitis type A. This condition affected young adult women ages 14-26 years at a ratio of 2.5:1 (to men).

During the adult phase of a woman's life, researchers followed menstrual cycles and noted a positive correlation to increased levels of gingival fluid (exudate indicates an inflammatory response). The authors acknowledge that other documentation contraindicated this research, noting no significant increase in gingival fluid levels with cyclical hormonal fluctuations.

Observation of pregnant women led a number of researchers to conclude that while elevated hormonal levels were not the primary etiological factor in the increased incidence of bleeding/gingivitis documented, there was a strong indication that the upswing in tissue inflammation was exacerbated by endocrine changes. Though less dramatic, similar reactions were seen in women using oral contraceptives. However, antibiotic therapy prescribed for women using oral contraceptives could significantly decrease the effectiveness of this birth control method.

It was documented that pregnancy tumours (histologically synonymous with pyogenic granulomas) are an exaggerated tissue reaction to local trauma, caused by the presence

of the hormones of pregnancy. Effective oral hygiene influences the response of the tissue to changing levels of estradiol and progesterone. Recommendation for thorough, regular dental prophylaxis was cited as a preventive measure.

The authors reference literature stating that 33% of post-menopausal women suffer from osteoporosis. With the subsequent decrease in alveolar bone mass/strength, a parallel was suggested between loss of bony support and an increase in periodontitis, tooth mobility and tooth loss.

The article concluded that hormonal changes may affect the periodontal supporting structures during various stages of a woman's life, and that females are more susceptible to both Juvenile Periodontitis and Rapidly Progressive Periodontitis type A. For the practitioner, a thorough understanding of the relationship between female hormones and periodontal conditions is significant in providing comprehensive oral health care.

Carol Barr Overholt graduated from the University of Pennsylvania, School of Dental Medicine, Department of Dental Hygiene in 1982. She has practiced clinically in Orthodontics, Periodontics, and General Practice. Currently, she is a full-time faculty member at Niagara College in Welland, Ontario in the Dental Hygiene program and is also completing a Bachelor of Education at Brock University. Carol has contributed abstracts, book reviews and self-tests to *Probe*; in future, she will be contributing an abstract of current research as a regular feature of *Probe*.

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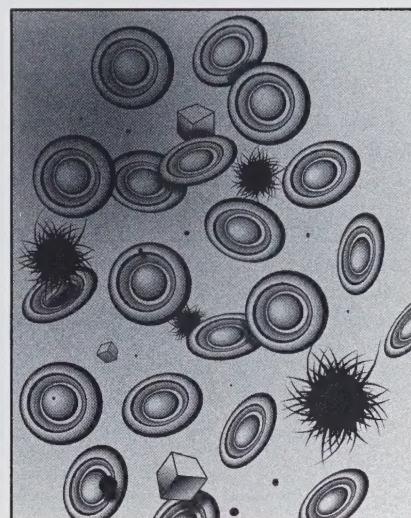
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Anti-Microbial Therapies

1. In periodontal disease, which type of facultative anaerobes are considered to be the most pathogenic? Those found in:
 - a) loosely adherent plaque
 - b) tooth attached plaque
 - c) bone attached plaque
 - d) connective tissue plaque
2. An ideal anti-microbial agent is usually thought to have the following properties:
 - a) aerobic; non-specific; topical
 - b) non-specific; quick-acting; topical
 - c) hypoallergic; anaerobic; systemic
 - d) specific; long-acting; non-toxic
3. Which of the following is (are) generally considered to have anti-microbial properties?
 - a) stannous fluoride
 - b) chlorhexidine
 - c) tetracycline
 - d) all of the above
4. When implementing the specially adapted probetip of an oral irrigator into a pocket, the clinician should use which of the following instrumentation principles?
 - a) work stroke; like a scaler
 - b) walk stroke; like a probe
 - c) cross-hatch stroke; like a curette
 - d) intermittent stroke; like ultrasonics
5. Oral irrigation with an anti-microbial is best performed as a/an _____ to scaling:
 - a) alternative
 - b) replacement
 - c) preliminary
 - d) adjunct
6. Locally administered anti-microbial therapy is best implemented:
 - a) during initial periodontal therapy
 - b) after surgical therapy
 - c) during maintenance therapy
 - d) in all phases of periodontal therapy
7. Chlorhexidine
 - a) has no significant side effects
 - b) has substantivity
 - c) is still considered experimental
 - d) is effective in the treatment of periodontitis
 - e) is available without prescription
8. An antibiotic currently being used successfully in some persistent cases of periodontal disease is:
 - a) tetracycline
 - b) sodium bicarbonate
 - c) metronomycin
 - d) sulfa-biotic
9. Oral irrigating devices have been shown to
 - a) reduce the incidence of juvenile periodontitis
 - b) promote healing after periodontal surgery
 - c) negate the effects of occlusal trauma
 - d) initiate keratinization of sulcular epithelium
 - e) none of the above
10. The addition of antimicrobial mouth rinses to power irrigating devices for home use:
 - a) has not been documented in the literature as an effective regimen
 - b) provides benefits beyond those achieved by irrigation with water
 - d) is effective in subgingival plaque control beyond 5 mm
 - e) should not be recommended for orthodontic patients
 - f) is not recommended by manufacturers of current irrigators



Virginia Cathcart, BA, RDH is an instructor in the Dental Hygiene program at the Vancouver Community College.

References:

- Woodall, Dafoe, Young, Weed, Yankell: **Comprehensive Dental Hygiene Care**. CV Mosby Co., 1993, 4th ed.
- Ciancio, S.G., Bourgault, P.C., **Clinical Pharmacology for the Dental Professionals**. CV Mosby Co., 1993, 3rd ed.
- Mosby's Comprehensive Review of Dental Hygiene**. CV Mosby Co., 1993, 3rd. ed.

Answer Key:

1. A	2. D	3. D	4. B	5. D
6. C	7. B	8. A	9. B	10. B

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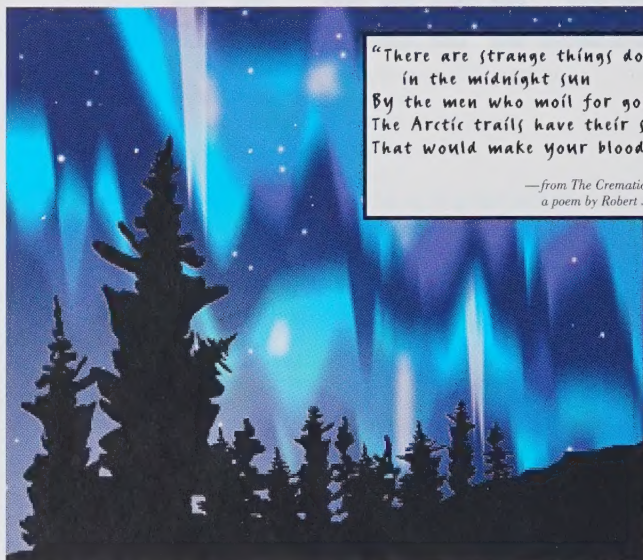
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—from *The Cremation of Sam McGee*,
a poem by Robert Service

Land of the midnight sun, pristine waterways, vast stretches of tundra reaching as far as the eye can see, and an abundance of extraordinary wildlife. A quiet and serene environment where one is at peace with nature... quite likely these are the images of Canada's northern frontier that flow to your mind when you think of the far North. Although, these images are very much a part of the northern experience, there is a less idealistic side also — one which demands a special tenacity for survival and an ability to adapt to nature's unpredictability. A reality that requires flexibility and an attitude that accepts that the North is different — and that what works "south of 60" may not be the solution in the North.

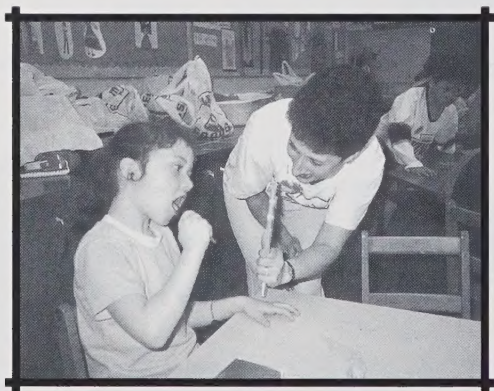
Take for example, the experiences of Mary Lea (Wright) Cathers, a 1966 graduate of the University of Toronto's Dental Hygiene Program. She claims that in 1979 she was the only practising dental hygienist in the Yukon. In a letter written in April 1986, Cathers recalls "having the

unique opportunity of packing up completely portable dental units and travelling to communities on road trips." She lived in Whitehorse and practised dental hygiene in the Yukon for two years before returning to the family farm located near Hanover, Ontario.

Then, in the spring of 1983, Cathers, her husband and their two children returned to the Yukon — this time to live in a cabin in the Yukon wilderness. A place with no road access and no neighbours closer than six-and-a-half miles across turbulent Lake Laberge. (Yes, the same Lake Laberge that witnessed the cremation of Sam McGee!) And for one year, while living in isolation, Cathers continued to work in Whitehorse for six dentists. During the winter months she travelled back and forth across the lake by dog team. Donned in mukluks, felt packs, a parka and a face mask, Cathers says that she learned how to endure the cold and avoid frostbite and hypothermia. She wrote that friends would monitor her and her family's lake crossings since anything could happen. "We have had our motor die in mid-lake at -30°C; rode on ice floes; propelled ourselves across candle ice using round-mouthed shovels; crossed during an earthquake; crossed high waves and on a mirrored surface."

"I am probably the only hygienist in our class who commutes to work by dog team or boat," she wrote in a letter forwarded to her colleagues at the University of Toronto reunion held in 1986.

Although Cathers experiences are indeed different, dental hygienists practising 'North of 60' today, still say there are unique challenges to be faced by the profession. Cultural diversity and limited resources are realities that must be addressed as they work to improve the oral health of Canada's northern inhabitants.



Dental Hygiene colleague Debbie Nider demonstrating oral hygiene practices to schoolchildren in a Yellowknife classroom.



Janis Kozak, Joan van Vliet, Nina Kuyt and Debbie Nider — dental hygienists with the spirit of adventure — practice in Yellowknife, NT. (Special thanks to Grant Beck, proprietor of Becks Kennels — "Home of the World Champion — Alaskan Dogs" for providing the unique setting!)

Joan van Vliet, a dental hygienist at the Yellowknife Dental Clinic graduated as a Preventive Dental Assistant from Durham College in Oshawa in 1975. She worked as a PDA in Kitchener, Kingston and in the Toronto area before returning to Durham College in 1979 to take the hygiene program. In 1991, van Vliet's path led her to Yellowknife. She notes that in Yellowknife "the challenges are greater and the professionals fewer, for a service much in need." However, on a positive note, she says that, "In the two-and-a-half years I have been here there have been positive changes, like the increased number of dental hygienists, which is exciting."



Pam Pierson (with the glasses) is a Dental Hygienist residing in Sanikiluaq, NT — the most southerly community in the Northwest Territories. Sanikiluaq is located north of James Bay on the Belcher Islands

Yellowknife resident, Nina Kuyt echoes van Vliet's words. Kuyt graduated from George Brown College in 1981. She then moved west to Calgary and worked in a general practice for seven years. In 1988-89 she travelled the Pacific Rim before returning to Ontario where she began to expand her career in an ortho/perio practice. "Those three years have proved to be invaluable to me here in Yellowknife," writes Kuyt.

Kuyt arrived in Yellowknife in the summer of 1990. She began working in general practice, one weekend per month, when the ortho team from Edmonton came to look after patients undergoing orthodontic treatment. She also spent several months "filling in" for other staff until a permanent position became available. An October expansion at the office has ensured a regular schedule of 2-3 days per week along with one ortho weekend per month. Kuyt agrees with van Vliet that practising dental hygiene in the North is challenging. "There are no specialists here except orthodontists," she notes.

Debbie Nider, another Dental Hygienist practising in Yellowknife, earned her diploma in dental hygiene from the University of Manitoba in 1972. In 1991 she returned to U of M to take the Refresher Program. Since moving to Canada's North in 1978 she has been actively promoting oral health in the public health arena. For several years she developed and delivered oral hygiene education programs in the public schools, preschools and to community groups, such as Cubs and Brownies. She also instigated the inclusion of Oral Hygiene Information Sessions in prenatal classes held in Yellowknife. Recently she has been delivering seminars to Community Health Representatives who work in the health centres in small northern communities and delivered full-day workshops at nursing in-service programs. Nider says that although, in general, oral health education is beginning to be recognized as an important aspect of one's total health, the North "is lagging behind in its attitudes toward oral hygiene."

Yellowknife resident and practising dental hygienist, Laurie Bembridge is a 1985 Algonquin College graduate. She's been practising in the North longer



Joan van Vliet is a dental hygiene colleague practising part-time in Yellowknife, NT. Here she is posing beside an Inukshuk — a common symbol in the North — it is an ancient symbol that was traditionally used by northern natives to indicate the direction of good hunting grounds.

than Kuyt and van Vliet and proudly notes that "for approximately six years she was the only RDH working (in a clinical setting) in the whole NWT." She has been a full-time employee for the past eight-and-a-half years at the Adam Dental Clinic, a busy general dentistry practice owned by Dr. Hassan Adam.

"We have just expanded and built a hygiene wing consisting of three hygiene rooms. We have all the luxuries possible and the entire clinic has also been recently renovated even though the clinic is just over six years old," writes Bembridge.

Bembridge says her employer is also very supportive when it comes to the question of remaining current. "My employer has always sent me to the University of Alberta in Edmonton for courses on periodontal scaling and root planing etc. to help keep me current," she writes.

She notes that she enjoys working in Yellowknife and expects to be there for many years to come. On a final note she adds, "It is hard to believe that all my dental hygiene experience has come from working up here and I am very happy to have more RDHs working here now."

Pam Pierson, a 1991 graduate from SIAST in Regina, Saskatchewan lived in Rankin Inlet, a small northern community located in the central Arctic in the Keewatin Region. Rankin is the transportation and administrative centre of the region. While in Rankin, Pierson says she practised dental hygiene for one year with Kiguti Dental Services. She has since moved to Sanikiluaq, NWT where she is unemployed. She says that one of the dentists from Rankin Inlet visits the community once every three months for a two-week period working basically 7 days a week and 12 hours a day. "There is never a shortage of work," she adds.

With so few practitioners in northern Canada, dental hygienists working there often feel isolated. At this time there are no CDHA component societies in the NWT or the Yukon. However, steps are now being taken to form a component society in Yellowknife. Dental Hygienists in the north say they are also concerned about the oral health and well-being of northerners. People in the north have limited access to registered dental hygienists who can provide assessment and periodontal therapy. With CDHA's support and guidance perhaps the scope of the dental hygiene profession can be expanded in the North and legislation governing it can be more closely monitored to ensure that northerners have improved and increased access to oral health care.

1993's National Dental Hygiene Week (Oct 17-25) proved to be a diverse event at Saskatchewan Institute of Applied Science and Technology (SIAST). To start off the week, a banner promoting Dental Hygiene Week was hung in the school's reception area. As well, Noel Selinger, Program Head of Dental Hygiene and Brenda Udahl, Program Instructor, promoted the career of dental hygiene at a Career Symposium held in Assiniboia, Saskatchewan. Approximately 2000 students, teachers, and adults from the Assiniboia School District attended.



Dental Hygiene Students and Instructor Brenda Udahl (right) from SIAST

Dental hygiene instructor, Irene Eckberg, participated in a public outreach program at an elementary school with the assistance of the 'Barkley the Beaver' project. The project, initiated by Wrigley's Canada, aided in promoting the importance of dental health on a commercial basis. This initiative is designed to heighten awareness and is welcomed by the dental profession.

The true 'egg-citement' of the week was the conducting of the fluoride egg experiment made popular by Procter & Gamble, makers of Crest. Dental hygiene students, with the assistance of instructor, Brenda Udahl, tried their hand at experimentation. The experiment was modelled after the Crest commercial, with the addition of two other independent variables. The additional variables were gel toothpaste with fluoride and topical fluoride (acidulated fluoro phosphate). The results were similar to those noted in the commercial, in that the portion of the egg receiving fluoride treatment was not decalcified. However the gel toothpaste and the topical fluoride did not protect against the decalcification action of the vinegar. The results caused by the gel toothpaste and topical fluoride lead one to question the validity of the conclusion that it is fluoride that is solely responsible for the results. Nonetheless, all participants agreed that the commercial proves to be an effective analogy of fluoride and its effects on teeth.

Students and instructors ended the week celebrating with a small get together which

included cake and conversation. As participating dental hygiene students we realized the thrust of National Dental Hygiene Week is more than recognizing dental hygienists and the importance of oral health. It is now evolving into a milestone in which dental hygienists recognize the need for diversification within the profession. This includes the promotion of careers within dental hygiene, increasing public awareness in all areas, and the importance of ongoing research.

*Submitted by: Alisa Arbuckle
Dental Hygiene Student
Saskatchewan Institute of
Applied Science and Technology*

Alisa Arbuckle is a graduate of SIAST's Dental Assisting Program and is now enrolled in the Dental Hygiene Program. She notes that she has a new awareness of the variety of roles Dental Hygienists play when carrying out their duties. She says she always envisioned Dental Hygienists in their clinical role before enrolling in the program and only since being in the Dental Hygiene Program has she discovered the degree of diversification the profession is undergoing.



Algonquin College Dental Hygiene Students — Scale Upwards with a New State-of-the-Art Clinic

When dental hygiene students at Algonquin College began classes in September 1993 they had the privilege of utilizing a brand new, state-of-the-art dental clinic, laboratory and classroom facilities. The clinic includes 28 complete treatment bays, 26 of which are operational. The remaining two are reserved for future growth and development. (The previous clinic was equipped with 24 bays.) The aqua and cream decor was created by interior

design students at Algonquin, providing a clean look to the facility. The new clinic also incorporates innovative air-treatment and computer technology in a refreshing setting.

"A 'laminar-flow air circulation' delivery system provides infection control," says Joan McEachern, Clinical Coordinator. "It also prevents harmful aerosols from staying in the room."

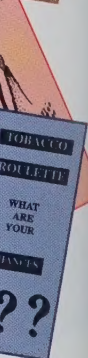
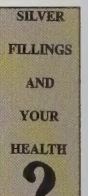
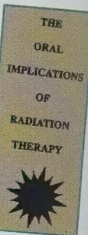
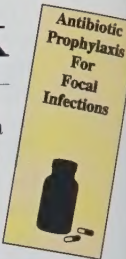
A new computer client-tracking system has been designed for the clinic by Ron Norris of Computer Services at Algonquin. "This program is unique to Algonquin," says McEachern, "It helps to screen patients based on their individual needs." The new dental clinic has been operational since mid-August. After several months of practice on mannequins, the dental hygiene students began working with clients in late December.

Algonquin continues to admit 48 students per academic year, in each of the Dental Assistant and Dental Hygiene Programs. In addition, the facilities are utilized by the Dental Hygiene and Dental Assistant programs at La Cité Collégiale where enrolment is 24 and 14 respectively. Consequently the clinic is utilized from 8:30 am-8:30 pm for three days and from 8:30 am-3:30 pm two days a week.

*Submitted by: J. McEachern
Clinical Coordinator*

Educating the Public — Dental Hygiene Students at Work

Vancouverites had an excellent opportunity to learn more about numerous dental health topics last November thanks to the efforts of 2nd year dental hygiene students of the Vancouver Community College. The students displayed their table clinics at the college's City Centre Campus on November 18th and invited all college students, health programs and the public to attend and learn more about dental health. Among the topics presented were: gum disease in children, tobacco roulette, micro-ultrasonics, silver fillings, sore jaws, guided tissue regeneration, antibiotic prophylaxis for focal infections, aesthetic restorations, halitosis and the oral implications of radiation therapy. Participating students developed attractive backdrops to attract attention to their topic of choice and designed information pamphlets for distribution.





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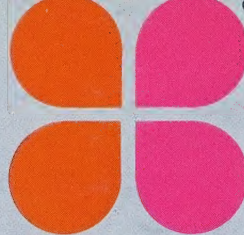
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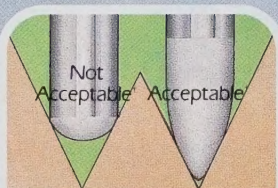
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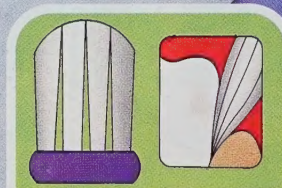
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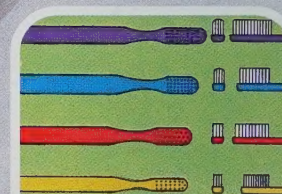
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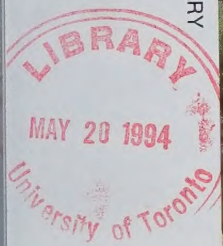
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VOL 28, NO 3

MAY/JUNE 1994 MAI/JUIN



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CANADA

Who's Giving the Orders?

By:
Dianne Landry, RDH, MDN, BA, BV/TEd

What does Dental Hygiene have to do to earn "professional status" in the eyes of the consumer, dentists, other health professionals and dental hygienists themselves? What can you do to help the cause? Many of us have the desire and energy to work toward such a cause...but where do we start?

Before we can answer these questions, I believe that we must understand what a professional is and then, accept the responsibility of acting as a professional. The literature tells us that some of the characteristics of a profession include: education in a specialized body of knowledge, self-regulation, an original research base, a service orientation, and ethics.

While many dental hygienists are actively promoting the movement toward the status of a profession, the changes facing Dental Hygiene today will require the full input of each of us if Dental Hygiene expects to remain (or more accurately regain) its rightful place in Canada's health care delivery system. We are building new bridges, but we should be careful not to tear down old ones in the process. Dental hygienists are dedicated professionals who wish to seek their place as a respected and trusted member of a *primary health care* profession.

Many dental hygienists have immersed themselves in the cause of actively promoting Dental Hygiene as a profession through their volunteer activities in our professional association. You should be familiar with their activities as their efforts have been extolled many times in this publication and in the Explorer. But what about you, the dental hygienist who practises in Fruitvale, British Columbia, Snowflake, Manitoba, or Rocky Harbour, Newfoundland. What are you doing each day to earn the respect of professional status?

This brings us back to the question, "Where do we start?" One might begin by examining each of the traits that define a profession. How do each of these fit with your daily actions?

Education in a unique, specialized body of knowledge: Dental hygienists are educated and trained to perform periodontal assessment, treatment planning, complex scaling and root planing procedures and soft

tissue management better than most dentists perform them. You learned a philosophy of care that is different. You know your dental hygiene care skills are more highly refined than other dental professionals because you had a lot more practical experience while in school. Furthermore, your licensure and livelihood depends on excelling in these skills.

Self-regulation: Eighty percent of dental hygienists in Canada are self-regulated. Unfortunately self-regulation is commonly interpreted to mean independent practice. Many dentists see the word "autonomy" and stop listening. Familiarize yourself with exactly what self-regulation means so that you can dispel the myths that surround the concept. This is *not* a new idea; many health professions have been self-regulated for years. Dental Hygiene self-regulation means that the profession will set the licensure and entry-to-practice requirements as well as education and practice standards. In concert with representatives of the public, we are prepared to regulate the practice of our profession.

*"You are a professional
the second you
believe it is so!"*

Research: It is necessary that every hygienist make a contribution to increasing, updating and validating dental hygiene scientific research. One way you can help is by reading the literature and applying the principles to your practice.

Even the most basic research based on participant observation conducted within the confines of your own practice can improve the quality of the client care you deliver. Why not write a report about your findings and submit it for publication in *Probe*?

Service orientation: Most of us would agree that our main reason for being is that our clients benefit from the quality of service we offer. We need to focus on productivity and quality. This does not mean focusing just on efficiency or how much you get done, and how quickly, but on the best ways to achieve the goal of individualized client care. Challenge and evaluate your current procedures. Identify the errors in your practice and judgment and then reduce or eliminate them. Fine tune your skills and your quality of work

will improve as well as your clients' oral health. How can you do this? Read and implement the CDHA's Practice Standards (1988). This fall, the revised practice standards will be explained and promoted at Quality Assurance Workshops throughout the country — make plans to attend when one is held in your area.

Ethics: Ethics are the backbone upon which all the other characteristics of a profession are supported. A code of ethics may be defined as statements of appropriate behaviour toward clients and colleagues. Each of you has received a copy of the Code of Ethics developed by CDHA. While a formal code of ethics is imperative for a profession, it has its limitations. It may not address every dilemma that you may face. Occasions arise when one principle conflicts with another, or the principle is so vague it has no practical application. In these situations you must rely on your own strength to follow an internalized value and belief system. Through years of experience and education you have developed a critical thinking process: assimilate information, arrive at a decision and implement it. If you need to sharpen your edge, consider attending the CDHA Professional Conference in June.

It is a time of fragile relationships. But progress towards recognition as a profession is impossible without a small amount of alienation. Progress requires the ability to take one's own agenda for change and help the opposition to see how the two views can work together. Be logical, play fair, build bridges without weakening your own position. Spend time discussing the issues with the public, dentists, other health professionals and your colleagues. Work towards an understanding of each other's perspective. You are a professional the second you believe it is so! 

Dianne Landry is the Editorial Director of *Probe*. She holds a diploma in Dental Hygiene (1966), a Bachelor of Arts (1986) from the University of Manitoba, a diploma in Dental Therapy (1976) from SIAST and a Bachelor of Vocational/Technical Education (1993) from the University of Regina.

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COVER

Glenda Butt is a 1969 graduate of Dalhousie. She played an instrumental role in the fluoridation of her home town of Corner Brook, Newfoundland before returning to Dalhousie to teach. She received a BA from Saint Mary's and a MEd from Queen's. Her current teaching in Communications and Clinical D.H. includes a review of students' videotapes and self-evaluations. She practices one day a week in general practice. Currently she is involved in qualitative research entitled Patients' Knowledge and Behaviour Related to Smoking and the Oral Cavity.

Glenda is active on University committees and has managed to achieve credit transfer for dental hygiene graduates toward a BA or BSc at Dalhousie. Outdoor activities include cycling down the west coast of Turkey (cover), hiking the Jotunheimen (Alps of Norway) and skiing the Okanagan powder amidst tree ghosts.

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We look forward to serving you.

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On Taking Care of Ourselves, Each Other and Our Profession

Dental hygienists promote the concept of wellness to their clients. We discuss health promotion at each conference and/or meeting we attend. We firmly believe in working towards goals that will improve the overall health of the general public. No question!! However, sometimes during this process, we neglect our *own* health and well-being.

Many individuals who aspire to enter the dental hygiene profession are "high achievers". The competition for entry into the program is fierce and the courses are extremely demanding. One has to work extremely hard just to survive. The current educational system encourages the dental hygiene student to strive to expand their knowledge and awareness which often involves working on several difficult projects, simultaneously. Is it any wonder that we continue this behavior as practitioners?

Clinical dental hygiene practice is specialized, detailed, repetitious and physically exhausting. In public health, industry and education our colleagues are being asked to assume more responsibilities in the face of a changing economy and social structure. Outside our practice, both this "restructured" economy and rapid technological changes are creating new demands on us, our families, our colleagues, our friends, and on society. Added to this, and in part because of these external changes, our profession is also at a crossroads and requires nurturing.

All these items are important, exciting, rewarding and exhilarating. But... is anyone tired yet? As we juggle all our responsibilities, energy and expertise we need to be mindful that what we build defines us. Taking time to assess, rest and rejuvenate are not extra, frivolous activities; rather they are key elements in the creative process. But juggling requires a delicate balance! To be success-



FRAN RICHARDSON COTTON
RDH, BScD, MEd

ful, society must balance the rights of the individual with the rights of the group. The individual must balance their enthusiasm and willingness to create and improve their practice, home, community and profession with the energy each of them possesses. Finding and maintaining this balance is perhaps the synonym for health.

How do we achieve a balance that will ensure personal success? One person's balance is another person's boredom or frenzy.

As individuals we need to pay attention to ourselves. When the red light comes on, the engine is overheated. It's time to pull over to the side of the road. (This is a hard one for me!) Nonetheless, it is critical that you take the time to define your level of positive energy. Identify activities that constitute recharging and then block time in your schedule for that revitalization. We need to listen to what others tell us about wellness. Many take great

joy and pleasure from their families; many find an outlet through membership in organizations such as Toastmasters, service clubs, and spiritual groups. Some include regular exercise or go to school either for credit or just for fun. Whatever you do, it needs to be something just for yourself.

As part of a profession/organization with a sense of purpose, direction and desired future, we need to take care of each other by setting reasonable, achievable goals. This June (1994) the pre-Board workshop will focus on streamlining activities, increasing efficiency (without increasing the workload) and shortening time commitments by reducing the number of meetings. For example, the education standards workshop has been rescheduled from June to the Fall.

As I conclude my year as President, I know that creating a balance is achievable for our association, as it continues to grow in presence and stature; for the volunteers, who give their energy and time; and for myself as I relinquish the responsibilities of this office. I urge you to be kinder to yourself. Listen to your intuition, support one another and enhance your time together. To those of you who are not or have never experienced burnout, congratulations! Let us in on your secret. 

Fran is currently Chair, Division of Dental Studies, College of New Caledonia, Prince George, BC. She received her diploma in Dental Hygiene from the University of Toronto in 1971, a BScD from the University of Toronto in 1982 and a Masters in Education from the University of Regina in 1987.

National Dental Hygiene Campaign 1994

October 16-23

Behind every great smile....

CDHA ACHD
The Canadian Dental Hygienists Association
Association Canadienne des Hygiénistes Dentaires

personal and professional dental care

En arrière d'une sourire éblouissant... le soin dentaire personnel et professionnel

From original material developed by the B.C. Ministry of Health

1994 marks the third year of the "Behind every great smile..." campaign and this year the campaign will focus on teenagers.

The goal of CDHA's National Dental Hygiene Campaign is to promote the awareness of Dental Hygiene as a distinct profession and to facilitate health promotion activities which will contribute towards improving the public's overall health. This year's special fact sheets will focus on general mouth care, smokeless tobacco and gum disease and will, once again, be available in both French and English. Tray-size posters picturing this year's target audience (teens) will also be available. Samples of both fact sheets and the poster will be included with the July/August issue of *Probe*.

If you aren't sure how to reach this year's target group, here are some suggestions the members of CDHA's Health Promotion Council recommend:

- Arrange to visit a local high school health class to deliver a presentation and while there pose the question: What is a Dental Hygienist and what does a Dental Hygienist do? (It would be interesting to discover the variety of responses students generate — and publica-

tion of the level of awareness amongst teens may help us to refine our approach to Health Promotion in the future.)

- Visit a local high school biology class and examine plaque through a microscope.
- Conduct a "Floss and Brush" demonstration.
- Offer nutritional and oral health counselling at a teen drop-in center.
- Conduct oral cancer screening at a high school.
- Develop and deliver a presentation on the harmful effects of 'smokeless tobacco' and smoking from an oral health care perspective.
- Set up a display in a video outlet, include a questionnaire on oral health care and offer a prize to the lucky individual who completely answers all the questions correctly and is randomly selected at the end of the week.
- Visit teen drop-in centres and/or community centres and offer information and complimentary samples of oral health care items (toothpaste/floss/toothbrushes).
- Develop an article on oral health care for publication in a high school publication.

- Conduct a Table Clinic at a Leisure Centre.
- Develop a visual display for a movie theater, the local mall or a sports store.
- Arrange to have advertisements noting Dental Hygiene week dates placed on buses and bus stop benches.

It's easy to get involved in NDHC and the important thing to remember is that YOU are your own best promoter. If you want the general public to know who you are and what you do — **you** are the best person to provide the information. Even by simply talking with your clients and explaining your role as you are working helps to educate them not only about the importance of good oral hygiene for their own personal benefit, but in addition, it helps them to understand your role as a dental hygiene professional and what dental hygienists can do for them. An important role every Dental Hygienist must play to be effective in their role is that of Health Promoter. It's important to be promoting the special knowledge, you, as a dental hygienist possess, and at the same time you can promote yourself and your profession — because only you can provide effective dental hygiene care to the many clients you see each day.

National Dental Hygiene Campaign

The National Dental Hygiene Campaign is the responsibility of CDHA's Health Promotion Council.

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Facts About Gum Disease			\$8.00	\$16.00	
Facts About Smokeless Tobacco			\$8.00	\$16.00	
Poster (small)			\$1.00	\$2.00	
SCHOOL AGED CHILDREN:					
Facts About Mouth Care			\$8.00	\$8.00	
Facts About Fissure Sealants			\$8.00	\$16.00	
Poster (small)			\$1.00	\$2.00	
OLDER ADULTS:					
Facts About Mouth Care			\$8.00	\$16.00	
Facts About Gum Disease			\$8.00	\$16.00	
Facts About Denture Care			\$8.00	\$16.00	
Facts About Oral Cancer			\$8.00	\$16.00	
Poster (large)			\$1.00	\$2.00	
Smile...for Life			N/C	N/C	
GENERAL:					
Facts About Dental Hygienists			\$8.00	\$16.00	
Facts About Oral Care			\$8.00	\$16.00	
Facts About Gum Disease			\$8.00	\$16.00	
Stickers with Crest-CDHA Logo	100		\$10.00	\$20.00	
Careers in Dental Hygiene Fact Sheet			\$8.00	\$16.00	
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1993 CDHA-AquaFresh Scholarship Award Winners Say "Thanks"

As the recipients of the CDHA-AquaFresh Scholarship we would like to extend our appreciation for this award. We were very honored to be two of the award winners. The opportunity to attend the CDHA Research Conference in Niagara Falls helped us to make a great start in our professional careers. We hope that future award winners will benefit as much as we have.

Sincere thanks,

*Natasha Kravtsov
Christy Cessford*

World Health Organization/Pan American Health Organization Fellowships

On behalf of Health Canada, the Canadian Society for International Health has announced details of the annual World Health Organization (WHO) and the Pan American Organization (PAHO) competition for fellowships for Canadian citizens wishing to undertake short-term studies abroad.

Some 10 to 15 fellowships up to a maximum of \$5,000 American each, are expected to be approved this year.

Health personnel eligible to apply include those persons who have finished their formal professional training, who have several years of experience, and who now wish to continue their professional development in a health-related field relevant to their work.

Fellowships are intended for persons currently working in the health system. Persons engaged in pure research, undergraduate and graduate

university students, and persons whose application is only related to attending an international meeting or conference, are not eligible to apply for WHO/PAHO fellowships.

Applicants for WHO/PAHO fellowships will be rated by a Canadian Selection Committee on the basis of education, experience, proposed area of study, field of activity and the intended use of their newly acquired knowledge. The final decision regarding the awarding of a fellowship rests with the World Health Organization/Pan American Health Organization.

Applicants must be received before June 30, 1994. Additional information and application forms can be obtained by contacting: WHO/PAHO Fellowships, Canadian Society for International Health, 170 Laurier Avenue West, Suite 902, Ottawa, ON, K1P 5V5 Tel.: (613) 230-2654 (ext. 309), Fax: (613) 230-8401.

British Columbia to Establish College to Regulate its Dental Hygiene Profession

Dental Hygiene colleagues in British Columbia have joined ranks with a majority of Canadian Dental Hygienists to become self-regulated. To date, more than 80% of dental hygienists practicing in Canada are self-regulated.

On March 7 British Columbia's Health Minister, Paul Ramsey announced that colleges of dispensing opticianry and dental hygiene would be established to regulate the professions and provide better protection for the public.

The BC Government accepted the recommendations of BC's Health Professions Council

that opticians and dental hygienists be self-governing under the Health Professions Act. This will allow them to set standards of education, impose practice standards and develop codes of ethics. Under the Act, the colleges will also be responsible for investigating public complaints and disciplining registrants who practice in an incompetent, unethical or impaired manner.

It is anticipated that the colleges will be established by June 1994 and one-third of the board members of each college will be public members. The boards will assume responsibility for developing bylaws to govern the practice of the two professions.

Dental Hygienists will continue to provide services, such as administering local anesthetic, currently delegated to them by the College of Dental Surgeons. And although hygienists working in dentists' offices will continue to require the direction of a dentist, specially qualified hygienists working in institutional settings or dental care programs will not require supervision.

The establishment of the College of Dental Hygiene follows extensive consultations, including public hearings and analysis of the practice and regulation of the professions in other provinces.

**Smile
... for Life**



'Smile...for Life Seniors Packages' in Demand

Due to an overwhelming demand for dental hygiene information for seniors, CDHA members can now receive, at no charge, copies of the Smile...for Life Seniors Package. The package includes information sheets with the following headings: Oral Health is Important, Your Teeth and Growing Older, Brushing and Flossing,

Fluoride for your Teeth, Diet and Your Health, Denture Care, Check Yourself, and Professional Care. Call 1-800-267-5235 and request your copies today! Please note that individuals requesting more than 50 copies will be asked to cover shipping and postage charges.

Maria Araceli Pacheco Memorial Award Established for Dental Hygiene Students at the University of Manitoba

Following the tragic death of Maria Araceli Pacheco on November 17, 1992 in Vancouver, British Columbia, her family has offered to establish a fund for students studying at the School of Dental Hygiene at the University of Manitoba.

Beginning with the academic year of 1993/94, an annual award valued at up to 70 percent of the annual interest on the fund, will be made to a senior student who, having successfully completed the second year Dental Hygiene Program, achieves a high combined average in Pathology, Pharmacology and Dental Hygiene and demonstrates professional promise and concern for patients, as exemplified by Maria Pacheco.

Donations may be made by sending a cheque, payable to the **Maria Araceli Pacheco Memorial Fund** to:

**Department of Private Funding, University of Manitoba
179 Continuing Education Complex
Winnipeg, MB
R3T 2N2**

A tax receipt will be issued for contributions by the University of Manitoba, Department of Private Funding.

Obituary

Maria Araceli Pacheco died suddenly on November 17, 1992 in Vancouver, British Columbia.



Maria immigrated to Canada from the Philippines at age 11. She graduated from Daniel McIntyre Collegiate (Winnipeg) in 1982. She contemplated careers in nursing and dental hygiene and chose the profession of Dental Hygiene, graduating from the University of Manitoba in 1984. Maria was also successful in obtaining American National Dental Hygiene Board Certification in 1985.

From 1984 to 1988 she held a position as an expanded function (restorative) dental hygienist with Drs. H. Diamond and L. Cogan at the Windsor Park Dental Clinic in Winnipeg. In 1988 Maria moved to Vancouver and assumed a dental hygiene position with Dr. Anu Rethlane where she practised until her tragic untimely passing. She was very active in the British Columbia Dental Hygienists' Association and regularly attended continuing education courses and seminars.

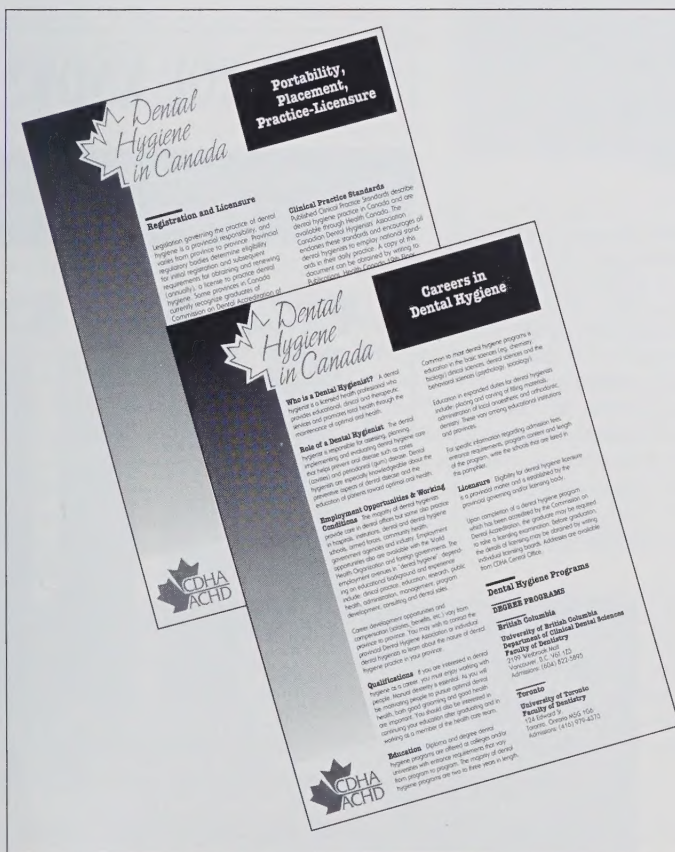
Maria Pacheco's colleagues and patients praised her for her sensitivity, friendliness, sense of compassion and efficiency. She will be sadly missed but never forgotten.

New/Revised CDHA Fact Sheets Now Available

The public has a right to know — and they *need* to know: who we are and what we do! Help your clients understand more about your role and profession — provide them with a copy of CDHA's newly released **Careers in Dental Hygiene** fact sheet that is designed to heighten awareness about the Dental Hygiene profession in Canada. CDHA recently produced two new fact sheets about the profession. **Careers in Dental Hygiene** details the definition, role, qualifications, education and licensure of Dental Hygienists in Canada and provides a complete list of Dental Hygiene Programs offered in Canada.

Educators will be particularly interested in the **Portability, Placement, Practice - Licensure** fact sheet. This fact sheet provides information about the registration and licensure procedures in Canada. (Useful information for students preparing to enter the profession.) It also discusses the definition of a Dental Hygiene Practice, Clinical Practice Standards, Code of Ethics, National Portability and Placement Services. In addition, this fact sheet provides a list of all the provincial licensing authorities and the provincial dental hygienists associations.

Both of these fact sheets are available in English in pads of 50 for \$8.00 per pad.



World Dental Experts Reach Consensus on Pathogens Associated with Periodontal Disease

According to a press release issued by Kodak Canada Inc. in January 1994, a consensus has been reached among leading experts who participated in a global symposium on periodontal diagnostics, identifying primary pathogens involved in the initiation and progression of periodontal disease. The symposium, held late last year in Orlando, Florida, was sponsored by Kodak.

The pathogens identified by the experts include *Actinobacillus actinomycetemcomitans* (Aa), *Prevotella intermedia* (Pi), and *Porphyromonas gingivalis* (Pg). Of these, Pi and Pg have been shown in a population-based epidemiologic study to be specific risk factors for periodontitis. Aa appears to be a risk factor in adolescents. Other risk factors include specific host susceptibility, smoking, infrequent dental care, age, diabetes and male gender.

Periodontal disease is a destructive process with a very complicated pathogenesis. There is no doubt that bacteria cause periodontitis, and without therapy, periodontitis leads to the loss of teeth.

Currently, there are no standardized tests to detect oral pathogens. Diagnosing periodontitis in its early stages is difficult, because individuals who have it, often have few symptoms.

In addition, it is difficult to differentiate early periodontitis from gingivitis (inflammation of the gums). "Diagnostic radiographic techniques are frequently helpful, but also are subject to misinterpretation or incomplete interpretation," said Dr. Bengt Rosling, a symposium participant who works in the Department of Periodontology at Helsingborg, Sweden.

According to another participant, Dr. Marjorie Jeffcoat of the University of Alabama in Birmingham, periodontitis is often not diagnosed because some dental professionals think they can see it by simply looking in the mouth, which is a fallacy.

The symposium participants agreed that new tests that would show active disease progression, or a higher likelihood of disease progression, or the

presence of specific pathogens that need to be acted on, were required. They suggested the need for tests that would tell them something that they could not see with their own eyes, with their probes or with radiographs in a single examination.

Symposium participants also agreed that lack of education about periodontal disease is a worldwide problem. "A significant number of patients are evaluating their own dental problems and, in effect, prescribing their own courses of treatment," said Dr. Michael Eggert of the University of Alberta in Edmonton.

Participants agreed that this lack of education also extended to dental practitioners who often raise concerns about the difficulty of diagnosing periodontitis in its earliest stages.

Kodak is currently marketing a chairside periodontal test in Canada and several European countries, following export approval by the U.S. Food and Drug Administration.

The Evalusite Periodontal Test accurately detects Aa, Pi and Pg in conjunction with clinical parameters, providing results at chairside within five minutes. The test is based on Kodak SureCell technology, which is used for in-office testing of chlamydia, herpes simplex virus, streptococcus A and pregnancy.

Pharmaceutical Manufacturers Association of Canada Introduces New Public Awareness Campaign

To encourage the proper and responsible use of prescription medicine, the Pharmaceutical Manufacturers Association of Canada (PMAC) has introduced a new public awareness campaign entitled, "Knowledge is the best medicine". The program is designed to encourage people to get involved in personal health care decisions involving medicines by simply talking to their physicians and pharmacists to get their questions answered. The program is also designed to prevent inappropriate medication use, a problem which can have a significant impact on the general health of the public and health care costs.

As members of the health care profession, Dental Hygienists may wish to advise their clients of the program, particularly if they learn that a client is using one, or several medications. According to the PMAC, the ad campaign is targeted at people over 50 years of age; the largest consumers of

prescription medicines. National television and print advertisements are encouraging Canadians to call a 1-800 number to request an information kit consisting of three booklets and a medication record. The booklets cover questions to ask doctors or pharmacists, personal guidelines for medication use, and suggestions for "living smart". Call 1-800-363-0203 to request copies of these publications to have available for reference in the dental office, or provide your clients with the toll-free number so they can request copies of the booklets.

In addition to the three main information booklets, 'Ask Me!', 'Knowledge is the Best Medicine' and 'Living Smart', PMAC has developed fifteen 'fact sheets' for various classes of drugs (for example, ulcer medications) which have been cleared for use by the Health Protection Branch of Health Canada.

DID YOU KNOW?

Percentage of full-time dual earners affected by time-crunch stress, 1992



Source: Statistics Canada, 1992 General Social Survey.

The Impact of Demographic, Economic and Social Trends on Oral Health Care

By:
J. Clovis, Dip DH, BEd, MSc

This paper was an invited paper presented at the North American Research Conference held in Niagara Falls in October 1993. Both Canadian and American content was included in recognition of the countries of origin of the conference participants, and to facilitate comparison.

Abstract

Concurrent with the new technologies in oral disease prevention, diagnosis, and treatment are the changing global perspectives on health which impact significantly on who will actually receive the new technologies and services. Issues of access to care, the rapidly changing social, political, and economic environments and the growing recognition of the disparities and barriers to oral health are stimulating new strategies for positive change and enhancement. Governments, in partnership with professional associations, private sector concerns and consumer interests in Canada and the United States, have recently reviewed current oral health status and identified needs and inequities. A few bold new multisectoral initiatives have evolved but not enough to address all the trends. The challenges not adequately addressed by current policies and practices have been identified. Goals for oral health have been established both nationally and internationally to address the trends and the challenges. Critical areas for taking action have been also been identified and include research in epidemiology, behavioural and social sciences, health services, and evaluation. This type of research considers the social and environmental context of where and how oral services are provided. Ultimately this is the kind of research that can radically change the role of the dental hygienist in the delivery of oral health care.



J. CLOVIS, DIP DH, BEd, MSc

Oral health professionals might say that this quotation from a recent unpublished Canadian report is self-evident. As oral health professionals we know and understand the implications of both oral disease and oral health in the individual. And we understand that, with the new science and technology in prevention, diagnosis, and treatment, a vastly improved service can be provided for patients. The purpose of this paper is to draw attention to the rapidly changing global perspectives on health which impact significantly on who will actually receive oral health services and the new technologies.

Trends in oral epidemiology and health determinants, health economics, and the regulation of health care affect the delivery of oral health care. Issues of access to care and the changing social, political, and economic environments are not new or recent, but the questions asked, and the solutions posed, are now stated with much greater resolution.

The framework of this paper is extracted primarily from two sources: the 1990 unpublished report by Health and Welfare Canada (now Health Canada) titled "Oral Health in Canada: Facing the Future"¹ and the "Statement of the Coalition for Oral Health"² presented on March 30, 1993 to the U.S. House of Representatives. At that time the Coalition had 14 member organizations representing many dental professional interests, although not including the American Dental Association.

These two reports, along with WHO³, Canadian¹ and American^{4,5} published goals for oral health, and United States President Clinton's health care proposal⁶, carefully summarize the emerging trends in oral health and health care, as well as suggest goals and strategies to improve the oral health of Canadians and Americans.

Emerging Trends

A. Oral Health Versus Dental Disease

One of the key issues addressed by both reports is the distinction between oral health and dental disease and the notion that the mouth is somehow not connected to the rest of the body. The extent

Oral health makes a vital contribution to personal well-being and the quality of daily life throughout the entire life span. Poor oral health, on the other hand, can cause significant disability, both for the individual and the community.¹

to which oral health and overall well-being are related is becoming increasingly clear. In fact, the very term "oral health" has been preferred to "dental health" and has been used for over 20 years by the World Health Organization. The term oral health implies not only the teeth but the entire oral cavity, and the use of the word "health" implies our more recent commitment to improving quality of life rather than simply treating dental disease.

Oral disease can be a significant source of disability and handicap for both the individual and the community. On the other hand, oral health makes a vital contribution to self-esteem and social interaction.

Some examples are the following. Cancer statistics for 1992 show that 1 in 50 cancer deaths in Canada and in the United States are due to oral cancer, a painful and disfiguring disease that is frequently overlooked until it has reached an advanced stage.^{7,8} About one third or more of adults over age 65 in both Canada⁹ and the U.S.¹⁰ have lost all their teeth. Among the edentulous, 40 percent complain of gastrointestinal problems, and among those who do not wear functional dentures, the percentage of those taking drugs for gastrointestinal problems doubles.¹¹ The economic toll on society includes in the U.S., in 1989, 20 million days missed from work and 51 million hours lost from school as a result of dental conditions.¹² In Canada, in 1987, 15 percent of a sample of Toronto adults reported that oral pain had some effect on their daily life in the past four weeks, and 1.7 percent took some time off from work due to oral pain within the previous month.¹³ Studies have shown that facial attractiveness influences the way in which parents, teachers, and employers judge people. In one study children who were ridiculed because of their teeth were more than twice as likely as other children to report generalized verbal or physical intimidation or victimization by their peers.¹⁴ In another study among people 50 years of age and over, one-third were dissatisfied with the appearance of their teeth or dentures and 10 percent avoided smiling or laughing.¹

B. Demographic Trends

A number of demographic trends are causing rapid and dramatic changes in Canadians' oral health status and health care needs.¹ The population of Canada and the United States is aging quickly. The number of adults aged 65 and older in Canada and the U.S., is approximately 12 percent and will double in the next 30 years. There is an increasing number of non-traditional households with more single parent families who are poor, and older people on restricted incomes. An increasing number of immigrants are from countries without preventive programs in oral health, and these immigrants require a broad range of oral health services. Indian and Inuit populations have significantly higher birth rates than non-aboriginal Canadians and typically have higher rates of oral health problems.

C. Disease Trends

Some trends in oral disease are well-documented; others are less clear.^{1,2} Fewer teeth are being lost and fewer people are losing all their teeth. Dental caries have fallen by 50 percent in most five-year olds. But still, almost the entire adult population experiences decay, and older adults are more likely than 14-year olds to develop dental decay.¹⁵ Periodontal health has improved and fewer adults have severe periodontal disease. But still, in the U.S., 60 percent of 14-17 year olds have evidence of bleeding gums,¹⁶ and 40 to 70 percent of adults (depending upon the age group) have infected gums.¹⁷ In Canada, as much as 88 percent of older adults need care for periodontal disease.⁹ The prevalence and incidence of oral health prob-

lems is higher in native people. In Canada dental decay among these children is three times that of other Canadians.¹

D. Trends in Oral Health Care

The trends in oral health care are becoming clearer. Inequities in oral health care are becoming more glaring.

1. Access to Care

While total health care is now available in some institutions and remote areas, the poor, the elderly, the institutionalized, the geographically isolated, and the medically, physically or mentally compromised are largely unable to gain access to oral health services.

For many groups and individuals dental insurance is a dream, and for many more the scope of services covered by dental insurance is narrowing. In 1989, about 62 percent of Americans lacked dental insurance¹⁷ and, in 1991, 49 percent of Canadians lacked dental insurance.¹⁸ The proportion of adults with dental insurance also decreases markedly after retirement.

"There is an increasing number of non-traditional households with more single parent families who are poor, and older people on restricted incomes."

In 1989, only 60 percent of Americans visited the dentist at all in the preceding year.¹⁷ In 1991 about 70 percent of Canadians reported visiting the dentist at least once a year.¹⁸

2. Escalating Costs

Oral health care costs include actual out-of-pocket costs to individuals, costs to businesses offering dental insurance as a health care benefit, and costs of public health programs, and all of these costs are increasing. Relative to total health care expenditures, however, dental care expenditures are decreasing. In Canada, dental care expenditures that were 5.8 percent of total health expenditures in 1980 decreased to 5.5 percent in 1989.¹⁹ In the U.S. the 1992 national expenditure for dental care constituted only 5.3 percent of personal health care expenditures.²

3. Oral Health Care Personnel

While an optimal mix of professionals and gender has not yet been realized, the types and numbers of oral health care providers are gradually changing. During the 1980's, the number of dental hygienists in Canada increased by 108 percent while the number of dentists increased by only 28 percent.¹⁹

Clearly, it is the least expensive dental services — the preventive services — that are the most effective in preventing and controlling oral disease and which will result in long-term cost savings to individuals and to society. Dental hygienists, as the primary providers of preventive services, are becoming a more significant component in the mix of providers.

4. Quality Assurance

Consumers and governments are increasingly interested in quality assurance effects in all health care. We all want good service at a reasonable, affordable cost.

E. Social Trends

Social trends also impact on health and health care. Many Canadians and Americans are adopting healthier lifestyles and have an increased interest in self-care. There is also a growing recognition of the effect of public policies and the environment on personal health. Consumers, professionals, governments and the private sector are increasingly interested in, and willing to collaborate on, health issues. As consumer awareness of health issues increases, people are demanding greater participation in health decisions.²⁰

Health policy is rapidly changing to encourage and include the participation of citizens and providers of health services in the planning and management of the health system. Other trends include accountability for the prudent use of limited resources, matching resources to health needs, orienting health policies to healthy outcomes; and requiring health professionals to become more accountable through improved education and regulation.^{1,2}

In the case of dental hygiene, the trend toward self-regulation has been evident for more than a decade.²¹ Whether or not this trend will be followed by a more liberal scope of practice is yet to be determined.

Challenges

The unpublished Canadian report identified major challenges that are not adequately addressed by current oral health policies and practices.¹ The need to increase prevention is foremost. While most oral health problems can be prevented through simple means, more efforts and resources are still directed toward the treatment of oral disease than its prevention. Dentistry has an extensive, well-researched set of cost-effective preventive procedures to draw upon. The two most common oral disorders — dental caries and periodontal disease — can be prevented by a combination of fluoridation, daily home care, an appropriate diet, and professional intervention in the form of topical fluorides, fissure sealants and prophylaxes. There is an urgent need to implement the most effective and efficient preventive measures and to direct them toward those Canadians and Americans at highest risk for oral disorders.

The second challenge is to reduce the inequities in oral health and access to oral health care that are apparent in Canada and the U.S.^{1,2} Dental caries rates differ markedly across Canada and are much higher among children from low-income families, and among low-income adults and older adults. By age 13, some native children in Canada have up to three times as much decay as the national average. Most of these individuals will lose their teeth by young adulthood. New immigrant children in Canada have very high dental care needs. Most older adults have untreated oral disorders. In Canada, about 70 percent of older adults have root caries.²² Even in affluent urban communities, 60 percent need oral health treatment including nine percent who need immediate treatment to relieve pain and 40 percent who need new dentures or repairs.²³ Seniors with limited mobility and those who are institutionalized are particularly disadvantaged. Basic oral hygiene is a major need among those in institutions.

In the United States, the Coalition for Oral Health has identified the following as representative of access and inequity problems: the working poor, children with special needs, the developmentally disabled, nursing home and long-term care residents, and middle class Americans who have lost their jobs.²

Identifying these current challenges is the first step in any planning process. Setting goals to meet these current challenges in oral health is the next step.

Goals for Oral Health

Goals for oral health have been established nationally and internationally.

A. World Health Goals for the Year 2000

As a part of the goal of "oral health for all in the year 2000" the World Health Organization adopted at its World Health Assembly in May 1981 the first global indicator of oral health status: "an average of not more than three decayed missing, filled, permanent teeth at the age of 12 by the year 2000". With this indicator as a guide, each country was expected to formulate its own national and provincial goals according to its situation and resources. Just as the infant mortality rate has been used to compare the health status of different populations, lower DMF rates should reflect improvements in oral health status. The following "global goals for oral health in the year 2000" were adopted by the General Assembly for the Federation in 1981:

- Goal 1:** 50 percent of 5-6 year olds will be caries free.
- Goal 2:** The global average will be no more than 3 DMF teeth at 12 years of age.
- Goal 3:** 85 percent of the population should retain all their teeth at the age of 18 years.
- Goal 4:** A 50 percent reduction in present levels of edentulousness at the age of 35-44 years will be achieved.
- Goal 5:** A 25 percent reduction in present levels of edentulousness at the age of 65 years and over will be achieved.
- Goal 6:** A data-based system for monitoring changes in oral health care will be established.³

In Canada the first global indication of oral health status — no more than three DMF teeth at 12 years of age — has already been exceeded in most provinces. There is, however, an ongoing paucity of national and provincial data for all other age groups. A recent application to NHRDP for a three million dollar grant to conduct a national survey of several age groups was rejected with a suggestion to seek joint funding with the provinces. This seems to indicate another funding war between the federal government and the provinces. In Nova Scotia a further initiative has been undertaken to seek provincial support, and reapplication has been made to NHRDP for a limited grant for a survey of children and adolescents.²⁴ This seems unlikely to happen in many provinces given the current political and economic environments, and the greatly diminished dental public health resources.

In the United States, the national surveys funded by NIDR provide national data on most age groups but do not sample all states so have limited use for program planning by individual states.²⁵

Adequate national data is requisite to monitoring our progress towards attainment of the global goals for the year 2000, as well as any goals we may establish for our individual countries, and regions within countries.

B. Canadian Goals for Oral Health

The Canadian government Steering Committee on Oral Health Promotion suggested the following as goals for oral health.¹

1. Promote oral health as an integral component of general health.
2. Place greater emphasis on oral health promotion and the prevention of oral disorders.
3. Minimize inequities in oral health by improving the oral health status of disadvantaged groups and communities across Canada.
4. Meet the oral health needs of the aging adult population within a comprehensive oral health program for all ages.

C. American Goals for Oral Health

Healthy People 2000 is a report of national health promotion and disease prevention objectives for the United States. It was prepared by a consortium of experts and national and state organizations, and was facilitated by the Federal Government.⁴ The sixteen oral health objectives are intended to improve oral health status, reduce the risk of oral disease, and enhance oral health services and protection. The objectives include specific targets for each of the following 16 focus areas.

1. Dental caries
2. Untreated dental caries
3. Tooth loss
4. Complete tooth loss
5. Gingivitis
6. Periodontal diseases
7. Oral cancer
8. Protective sealants
9. Water fluoridation
10. Topical and systemic fluorides
11. Baby bottle tooth decay
12. Oral health screening, referral, and follow-up
13. Oral health care at institutional facilities
14. Regular dental visits
15. Oral health care for infants with cleft lip and/or palate
16. Protective equipment in sporting and recreation events

The Healthy People 2000 oral health objectives have explicit targets and are based on estimates by expert panels of what can be achieved from baseline data given trends in the determinants of oral diseases, resources available to control disease, anticipated techno-

logical advances that may help improve primary and secondary prevention, and shifts in Federal, State, and local priorities.

The Healthy People 2000 objectives and the Model Standards are provided as a guide for action by state and local communities. The Model Standards clearly delineate the focus area and topic, the objective, and the indicator for success.⁵ They also suggest that communities develop special population targets for community-specific subpopulations; for example, selected age, race, sex, income, and/or other high-risk groups.

This model of major national effort is something only dreamt about in Canada. The ultimate goal of the Canadian Steering Committee on Oral Health was to place oral health on the national health agenda but, to date, the report and recommendations have only been publicized in venues such as the C.D.H.A. National Conference in June, 1991, and the North American Research Conference in October, 1993.

Strategies for Change

Numerous strategies have been suggested as the means to achieve the oral health goals that will ensure equitable access and positive oral health for all.

A. Canadian Recommendations

The recommendations of the Canadian Steering Committee on Oral Health Promotion are to use a health promotion approach as a broad strategy combined with three specific oral health strategies. These strategies are intended to enable all Canadians to attain and maintain a level of oral health that enhances their quality of life.¹

A health promotion approach for Canada is described in *Achieving Health for All: A Framework for Health Promotion* a discussion document released by the Department of National Health and Welfare in 1986. It identified the major health challenges and described the health promotion mechanisms and implementation strategies necessary to address them.²⁰ The three mechanisms for accomplishing health promotion are self-care, mutual aid and healthy environments. Each of these is central to the maintenance of oral health. The self-care techniques that will enhance prevention are well known. As new self-care techniques become available, oral health promotion will be based even more solidly on personal care. Mutual aid means support to and from others that reduces our susceptibility to illness and enhances our ability to cope with ill health and to care for ourselves. Mutual aid can enhance the learning and maintenance of optimal oral health behaviours. The third mechanism, creating healthy environments, has a very classic example — fluoridation. Despite the ongoing discussion and debate, fluoridation is still beneficial to children and adults. Even in areas where dental decay has declined, fluoridation continues to be an important preventive mechanism for disadvantaged groups because it reaches everyone in the community.

The three major strategies that were identified in the *Achieving Health for all Framework for Health Promotion* — fostering Public Participation, strengthening Community Health Services, and coordinating Health Public Policy — also apply to oral health promotion.

The specific strategies for oral health include first, adopting a broad health promotion approach to emphasize the co-operative efforts that are required of individuals, communities, professionals,

and governments to enable people to increase control over, and to improve, their health, and second, to adopt three specific strategies to improve access to appropriate oral health services, plan for appropriate oral health personnel and establish an adequate data base. Access to appropriate oral health services could be improved by removing some of the many financial, geographic, culture, language, and psychosocial barriers to care. Planning for appropriate oral health care personnel is a specific strategy which is ill-addressed by governments and the professions. It is clear that we have not answered the questions about how many and what kind of dentists, dental hygienists, dental assistants, dental technicians, and denturists we need. Finally, in Canada, as identified earlier, there is some comparable data on 12-14 year olds by province but no other comprehensive data on other ages. A solid data base is fundamental to planning for oral health promotion activities, personnel needs, and changes required in the current systems of oral health care.

B. American Initiatives for Oral Health 2000

In the United States, the American Fund for Dental Health, a major health foundation, has convened a combined public, private and voluntary sector initiative to improve the oral health of Americans, called Oral Health 2000.²⁶ Former U.S. Surgeon General Dr. C. Everett Koop has endorsed a variety of programs centered around the prevention of oral disease and the need to consider oral health a component of overall wellness. Oral Health 2000 invites government, consumer groups, industry, foundations, and health professionals to collaborate in this initiative and to lead it into the next decade. In addition to the development of new and innovative cooperative programs, Oral Health 2000 is intended to tap into existing health and social service programs, particularly for high risk populations such as the indigent, handicapped, and medically compromised.

C. Recommendations of the U.S. Coalition for Oral Health

The goal of the U.S. Coalition for Oral Health was to have the United States government agree to provide a basic package of preventive and primary care benefits, including oral health benefits, to all Americans. The benefit package recommended by the Coalition was intended to incorporate the basic diagnostic, preventive, and treatment services that have proven effective in preventing and controlling dental caries, periodontal infections, pain, soft tissue pathology, trauma, and orofacial defects. The position of the Coalition is that Americans with employer-paid health insurance should have basic oral health benefits in the same way as they have insurance coverage for the rest of the body.²

The total cost of this basic preventive and primary oral health package for children and adults as envisioned by the Coalition is approximately \$7.1 billion. This is estimated to cost \$9 per person per month if the government assumes all costs in addition to current dental Medicaid for those who are at, or below, 200 percent of the poverty level.

D. The Clinton Plan for Health Care in the United States

On September 22, 1993, President Clinton announced his proposal for a new framework for health care in the United States. The Clinton plan, entitled "The American Health Security Act", would guarantee comprehensive health care coverage for all Americans regardless of health or employment status.⁶ The proposal uses financial incentives to encourage consumers to join low-cost insurance

plans while fostering competition among plans as a strategy to reduce costs and to improve services. The proposal calls for the development of health alliances to be run by the states under the federal scrutiny of a seven-member National Health Board appointed by the President. All citizens and legal residents would be covered. Employers would pay at least 80 percent of the cost of premiums while employees would contribute 20 percent toward their insurance premiums. Self-employed and non-workers would be required to buy insurance unless they qualify for government subsidies. The average cost is estimated to be \$1800 a year for an individual and \$4200 for a family.

Dental services under all plans would currently be limited to preventive care for all children up to age 18 but a removal of the age limit on preventive care is to be phased in by the year 2001. The low-cost insurance option for consumers is similar to a health maintenance organization. Under this low-cost plan consumers would pay \$10 per visit for preventive dental care for children under age 18. By the year 2001 the age limit on preventive care will be removed and consumers will pay \$20 per visit for restorative treatment, or for orthodontic treatment only for the purpose of avoiding reconstructive surgery. Under the high-cost plan consumers would pay 20 percent for preventive dental care for children under age 18. By the year 2001 the age limit would be removed on preventive care and restorative treatment would be provided for a \$50 deductible plus 40 percent of the cost to an annual limit of \$1500. Orthodontia would cost the consumer 40 percent to a lifetime limit of \$2500 under this high cost plan.

It has been suggested by many U.S. benefits consultants that dental benefits are likely to play a diminished role in future health care coverage negotiations and, even more important, that dental benefits for employees may even disappear if employees have to pay their own premiums or benefits are taxed. Benefit analysts have suggested that the American Dental Association did not lobby during the health care debate and will pay the price for this oversight. The ADA's Executive Director was quoted as saying that although dentists are dismayed by the Clinton proposal, the ADA is adopting a "wait-and-see" attitude before determining its strategy.²⁷

The Clinton proposal does not suggest what will happen to existing dental public health programs, nor is there any reference to the role of dental public health programs in the future.

E. World Health Organization Year of Oral Health

The World Health Organization has designated 1994 as the Year of Oral Health. April 7, 1994, World Health Day, was the beginning of a year-long celebration. This is the first time in the 44 year history of the World Health Organizations' annual recognition of special needs and interests that the focus will be on oral health. Many health professionals and associates have planned events to enhance awareness and appreciation of oral health with a particular focus on expanding the use of dental sealants for children, increasing patient education efforts, and prevention of child abuse.

Action

Some critical areas for taking action were identified by the Canadian Steering Committee on Oral Health Promotion and these are sufficiently broad-based that they may also apply to the United States.¹

1. Consumers and communities must be involved in the identification and development of oral health needs and services.
2. Comprehensive oral health education programs are needed, and these must be relevant to the cultural and linguistic needs of high-risk groups.
3. Resources are needed for periodic oral health screening to identify high-risk populations and to provide for appropriate follow-up services.
4. Accreditation of education programs for oral health professionals must ensure that health promotion is emphasized and that the curriculum responds to changing social needs.
5. Both private insurance and public programs must give greater emphasis to oral health promotion and cost-effective preventive procedures.
6. National, provincial, territorial and regional base-line data on oral health status, access to oral health care, and attitudes and behaviours towards oral health are essential. Oral health must be included in any future national health surveys.

These recommendations can provide direction for dental hygiene education, practice, and research. Dental hygiene is evolving as a profession with theoretical and conceptual underpinnings and a rapidly developing knowledge base. Concurrent with this explosion in new technology, clinical practices, and theory development are social, political, and economic changes that are fundamental to the development of strategies designed to address the goal of oral health for all.

Dental hygiene research must include epidemiological, behavioural, social, health services and evaluation research, and this research must be conducted in settings that are directly applicable to specific target populations. This kind of research considers the social and environmental context of where and how oral services are provided. Ultimately this is the kind of research that can radically change the role of the dental hygienist in the delivery of oral health care.

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Joanne Clovis is a graduate of the University of Alberta and holds a diploma in Dental Hygiene and the degrees of Bachelor of Education and Master of Science. Her professional career has spanned a broad range of private practice, public health, public and dental hygiene education, administration and government consulting. She is currently Associate Professor and Director of the School of Dental Hygiene at Dalhousie University.

Periodontal Therapy: Prospects for the Future

Reviewed by:
Carol Barr Overholt, RDH

By:
Roy C. Page
Journal: *J Periodontology* Aug/93
(supplemental)

The article *Periodontal Therapy: Prospects for the Future* begins with a historical review of periodontal disease treatment.

The surgical mode of pocket elimination used in the 1950's progressively became more sophisticated and in the 1970's root planing was added as a concurrent therapeutic component. However, neither the surgical or non-surgical approach appeared to demonstrate measurable periodontal attachment regeneration.

The accepted traditional therapeutic approach of closed debridement continued through the 1980's. However, through experimental observation, researchers concluded that microbiology and infection control of the pocket environment had more to do with the success of treatment than the surgical elimination of periodontal pockets. Complete pocket elimination was no longer the goal, but rather control or elimination of the pathogenicity of microorganisms in the pocket.

Antibiotic therapy is the current focus of experimental energy, with emphasis on slow-release mechanisms of local antibiotic delivery. In conjunction with the traditional treatment choices of scaling and root planing (with or without a surgical component), antibiotic chemotherapy (local or systemic) may also be included. Amoxicillin, doxycycline and metranidazole, alone, or in combination, are emerging as possible controls of progressive periodontal deterioration that does not respond to traditional therapy.

1990's research is adding new approaches to the control and elimination of periodontal disease. Three therapies are emerging: 1) debridement via scaling and root planing; 2) antibiotics/ antimicrobials targeting pathogenic bacteria within the pockets; and 3) altering the host-response mechanisms with drugs.

Increased knowledge of the routes by which the periodontium is destroyed has led to treatment that focuses on altering the host-response. Biologic by-products of the human inflammatory response, identified as tissue destroyers, can be altered with pharmacologic intervention. Anti-inflammatory medications like Naproxen appear to block alveolar bone resorption and contribute to bone apposition. It appears that tetracyclines favourably control some of the enzymes of inflammation considered to be the principal chemical mediators of periodontal destruction.

With these approaches in mind, researchers now expect that the next step in the treatment of periodontal disease will be the regeneration and restoration of tissues previously destroyed. The author questions the practicality and reliability of this approach.

Currently, bone-grafting procedures are being used with some success. The hope is that grafts of bone, or bone substitutes, either may stimulate new bone, or act as "scaffolding" upon which new bone can develop. Infrabony or vertical defects are currently treated by grafting with the host's bone (autograft), freeze-dried bone (allograft), or bone substitutes such as hydroxyapatite ceramic.

Further developments in research have led clinicians to determine that delayed epithelialization in wound healing and guided tissue regeneration may develop new periodontal tissues. Gore-Tex, for example, provides a barrier to the attachment of new epithelium to the tooth. Delaying this step allows the differentiation and proliferation of periodontal ligament (PDL) cells, that form new alveolar bone, cementum and PDL tissues. Guided tissue regeneration may also be used in conjunction with a graft procedure.

Another area of research is the use of citric acid and coronally-positioned flaps. Bone formation is stimulated by partially decalcifying the root surface with citric acid, thus enhancing the healing process.

The newest frontier of periodontal research is the study of growth factors. These include biochemical mediators that control the development of connective tissue and synthesis of tissue proteins that regenerate the periodontium. Research in these areas is promising but the author indicates that further study is needed.

Many of the previously mentioned therapies are providing some success in the treatment and elimination of periodontal disease. However, the article concludes that the most significant and successful treatment is the "quality and thoroughness of root debridement, not the presence or absence of a periodontal pocket." This is of great significance for the Dental Hygiene profession.

The author is optimistic about the future. He concludes that the goal of the treatment of periodontal disease will be to regenerate periodontal attachment through complementary therapies combining both traditional treatment and the newer methods outlined in this abstract.

Carol Barr Overholt graduated from the University of Pennsylvania, School of Dental Medicine, Department of Dental Hygiene in 1982. She has practiced clinically in Orthodontics, Periodontics, and General Practice. Currently, she is a full-time faculty member at Niagara College in Welland, Ontario in the Dental Hygiene program and is also completing a Bachelor of Education at Brock University.



By:
Lorraine Boomhour, RDH

Refusal of Treatment

Have you ever been rejected, refused or denied treatment of any kind? Recently in my community, two instances have come to my attention where HIV positive clients have been denied dental treatment.

One of these individuals told me that they felt their intelligence had been insulted. "How do they (the dental staff in the practice) manage to keep all the rest of their patients healthy without infection control? I'm the one who needs protection. Would receiving treatment at that office be safe for me?" the person asked.

Many people who are carriers of HIV or HBV are unaware of their infected state. Furthermore, because of the stigma attached to these diseases, people who are infected are usually reluctant to admit that they have tested positive. A complete oral examination/medical history may not reveal any signs, symptoms or information about an infectious disease. Consequently, we must accept responsibility for developing and implementing a universal infection control protocol in the dental office that will protect the clients, the staff and their families from cross-contamination.



LORRAINE BOOMHOUR, RDH

It is, without a doubt, difficult to live with the knowledge that one has tested positive for HIV or HBV. And, it is the responsibility of every dental professional to ensure that these individuals do not have to live with the added worry of wondering where they will be able to get oral health care. In the early stages of these diseases it is particularly important for the client to receive preventive dental hygiene care. The oral cavity is a part of the body that is often affected very early by disease, and in a client with AIDS opportunistic diseases in the oral cavity can cause much pain and suffering. Although it may be advisable for individuals in an advanced stage of an infectious disease (or those who are medically compromised in other ways) to seek treatment in a specially equipped facility, **primary dental hygiene care can very easily be provided to these clients in a general dental practice, by the dental hygienist.**

The CDHA Code of Ethics states that, "Clients seeking dental hygiene care will receive quality care regardless of religion, ethnic origin, social status, sex, sexual orientation, age and health status." It also states that, "The dental hygienist has a commitment to the welfare of the clients in all practice settings, including but not limited to private practice, institutions, research, education, administration and community health." In addition, it is worth noting here that the Canadian Dental Association's Board of Governors has approved the following statement: "A dentist must not refuse to treat a patient on the grounds of the patient's HIV or HBV infection status."

It can be a special privilege to provide dental hygiene care for a client with a life-threatening illness, regardless of the nature of that illness. These people also need our emotional care and support. As health professionals dedicated to improving the overall health of the general public we must be sensitive and empathetic to these individuals who are, in many cases, grieving over lost opportunities, reduced energy and impending death. These clients, above all, need time to ask questions and to be listened to, so that they may make informed decisions about their own health care. They have a right to make choices about treatment they may require and, although we may not be able to heal their disease, we can go a long way in helping to heal their spirits.

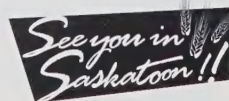
• Is it ethical to deny clients with home care requirements direct access to the services of a dental hygienist?

• What do I do when a client/insurer has been billed for more than I have done?

• My employer wants me to do what I can in the 2 units paid for by insurance every 6 months — but the patient needs more than this. How do I handle this?

• I work two days a week in a dental office. When I am not there, a dental assistant is doing the scaling for patients. What can I do about this?

**FOR ANSWERS TO THESE QUESTIONS,
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Lorraine Boomhour, of Brampton, Ontario received her Dental Hygiene Diploma in 1978, and obtained her Expanded duties in Dental Hygiene in 1979. She has been active in both CDHA and ODHA for many years and is a CDHA past-president (1992/93). She is currently in private practice.

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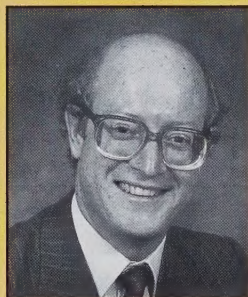
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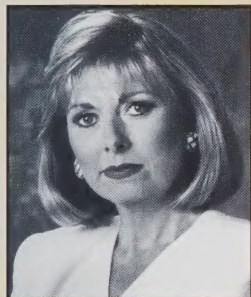
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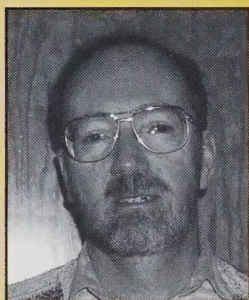
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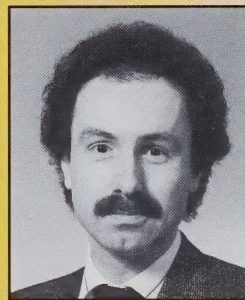
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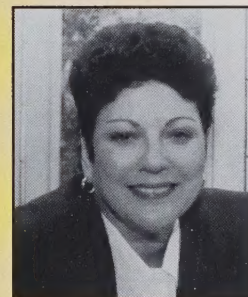
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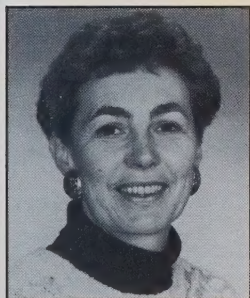
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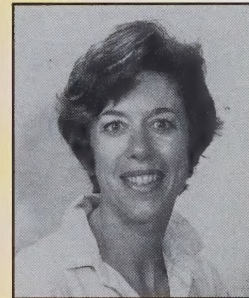
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Agenda

Friday, June 17, 1994

TIME	SESSION	ROOM
8:00 - 1:30	Opening Greetings	Battleford Room
1:30 - 3:30	"Saving Medicare — The Power and The Glory" Michael Rachlis, MD, MSc, FRCPC	Battleford Room
3:30 - 3:45	Break (outside Battleford Room near Registration Area)	
4:00 - 5:00	New Clients/New Settings/New Questions — Ethical Questions to Consider When Meeting the Needs of Special Client Groups Maxine Borowko, RDH, SDT, Cert V/T Ed Lynn Guest, RDH, BHE (MSc Candidate)	Adam Ballroom
7:00 - 9:00	Class Reunions	Delta Club Lounge

Agenda continues inside...

Agenda

Saturday, June 18, 1994

TIME	SESSION	ROOM
7:30 - 8:30	Continental Breakfast/Registration	Terrace Lounge
8:30 - 9:45	"Dental Hygiene and Health Care — Coming to Terms with the Ethical and Moral Dilemmas" Brent Cotter — Deputy Minister of Justice, Deputy Attorney General, Province of Saskatchewan	Adam Ballroom
9:45 - 11:00	"Applied Ethics in Dental Hygiene Practice — Voicing Our Value" Gary Chiodo, DMD	Adam Ballroom
11:00 - 11:15	Break	
11:15 - 1:00	"Nobody Told Me There Would Be Days Like This — A Decision-Making Process for the '90s" Marg Wilson, RDH, BEd, Jenny Thomas, RDH, BA, MEd LIMITED ATTENDANCE — PRE-REGISTER FRIDAY	Salon Batoche
11:00 - 1:00	Free Papers 11:00 - 11:30 Change in the Social Organization of Health Care Delivery — Lynda McKeown Mickelson, RDH 11:30 - 12:00 Patient Compliance for Implant Maintenance — Karima Bapoo-Mohamed, RDH 12:00 - 12:30 Continuing Education — An Ethical Concern — Charla J. Lautar, RDH, PhD 12:30 - 1:00 Examining Attitudes Towards AIDS Patients — Louanne Keenan, RDH	Kelsey Room
1:00 - 5:30	COMMERCIAL EXHIBITS/Table Clinics/Poster Sessions	Foyer
1:00 - 2:30	Buffer Lunch	Adam Ballroom
5:30 & 6:00	Buses depart for Western Development Museum — Saskatchewan Express (1 hour of entertainment) — Tour of Boom Town (1 hour) — Dinner (including cocktails)	
11:00 & 11:30	Buses return to Delta Bessborough	

Sunday, June 19, 1994

8:30 - 9:30	Panel I — Can Ethics Be Learned? Moderator: Marnie Forgay, Dip DH, BEd, MA Panelists: Nancy Prowse, Dip DH, BA, MEd Nancy Keselyak, RDH, MA Gary Chiodo, DMD Sharon Compton, RDH, BA, MA(Ed)	Halifax, NS Port Coquitlam, BC Portland, OR Edmonton, AB	Battleford Room
9:30 - 9:45	Break		
9:45 - 11:00	Panel II — The Ethics of Access to Care Moderator: Jenny Thomas, RDH, BA, MEd Panelists: Rick Holock, Benefits Consultant, Canadian Actuarial Irene Klatt, Canadian Life and Health Insurance Association Norm Lemke, Director of Human Resources for the Renfrew County & District Health Unit An informative panel-style presentation in which participants will discuss where dental plans and dental hygienists fit in, in the great big world of group insurance. Panelists representing the insurance industry, the benefit consulting community, and the employers will talk about regulation, cost, and other issues that affect access.		Battleford Room
11:00 - 1:00	Brunch with Guest Speaker Pamela Wallin		Adam Ballroom
1:00 - 2:15	"The California Vision" (or How a Peace Time Manoeuvre Turned into a War) Toby Segal, RDH, BS		William Pascoe Room
2:30 - 3:30	Panel III — New Practice Arrangements Moderator: Sheryl Feller, RDH, BA, MBA, CMC		Battleford Room

Abstract Presentations

The following Free Paper Presentations will be delivered on Saturday, June 18th from 11:00 am - 1:00 pm in Salon Baroche.

Change in the Social Organization of Health Care Delivery

Lynda McKeown Mickelson, RDH

Lakehead University — Sociology Department

On December 31, 1993, the Regulated Health Professions Act and 21 profession specific Acts, including the Dental Hygiene Act, were proclaimed in Ontario. This legislation provides for the evolution of a free, flexible, cooperative environment in which dental hygienists can provide their authorized acts. The presenter suggests that this legislation is an example of social progress as it changes the social organization of health care delivery. Although the present medical treatment model of health has been effective, it is an expensive and incomplete approach to health care. It limits consumers' options for alternative health care and it maintains a hierarchy of health occupations. As society evolves from the medical treatment model to a preventive model of health, dental hygienists are well positioned to cooperate with clients and other providers to assist in attaining total health through oral health.

The new Ontario legislation emphasizes accountability of professionals. Thus, dental hygienists are accountable and responsible for their professional actions to their governing College of peers and public, not to dentistry. However, ongoing dialogue with dentists and other professionals and clients is necessary if appropriate treatment/care is to be decided. To think independently to make decisions in the best interest of the public and to work cooperatively with dentists and other professionals to achieve the most beneficial results provides a challenge. The College of Dental Hygienists of Ontario is developing guidelines and a code to assist practitioners in resolving inter-professional conflicts and dilemmas.

To accomplish the research, the qualitative methods of participatory observation and case study analysis have been used. In addition, the presenter draws upon personal experience with the self-regulatory bodies of dentistry and dental hygiene.

Patient Compliance For Implant Maintenance

Karima Bapoo-Mohamed, RDH

Vassos Implant Learning

One of the issues faced in a dental office is motivating patients to practice sustained oral hygiene routines. This situation is amplified in an implant practice where patients may have been wearing removable prosthesis for most of their lives and may lack the skills to perform home-care routines. This paper will share an established protocol of an implant office to overcome this issue.

The cause of tooth loss is determined at the first appointment to equip the clinician with the patients' past dental experiences. The patient is made aware of the hygiene expectations of their future implants. Following the osteo-integration healing period, the implants are brought into function by placement of abutments. At this appointment, a customized home-care regimen is set up depending on the patients manual dexterity and medical limitations. Short recall appointments are established thereafter to monitor the patient's efficacy in deplaqueing their newly acquired implant prosthesis. New home-care aids such as electrical brushes and water irrigation systems may be indicated for progressive recall appointments.

Careful case selection, introduction of the maintenance expectations prior to implant placement, customized home-care routines, frequent initial recalls and continual dialogue between patient and clinician are some of the factors leading to success in achieving patient compliance to implant maintenance.

Continuing Education: An Ethical Concern

Charla J. Lautar, RDH, PhD

University of Alberta

An ethical issue in dental hygiene is quality of care. The Code of Ethics of the Canadian Dental Hygienists Association states that dental hygienists are ethically committed to provide a constantly improving care to their clients and that this should be achieved through continuing education. The purpose of this study was to investigate the perceptions of dental hygienists in Alberta regarding mandatory continuing education, reasons for participation in continuing education, and future continuing education needs. Surveys, consisting of both open and close ended format questions, were sent to 166 dental hygienists selected according to employment status indicated on the membership list of the Alberta Dental Hygienists Association. The response rate was 67% (n=111). An overwhelming majority (92%) of respondents indicated that continuing education should be mandatory. Increase in quality of care was indicated by 84% of subjects as the first reason for participation in continuing education. In addition, 40% of respondents indicated that courses specifically in clinical dental hygiene would be required for future continuing education needs. The results of this study suggest that mandatory clinical courses should be an essential element in continuing education in order to ensure high standards of quality care to clients.

Examining Attitudes Towards AIDS Patients in an Attempt to Understand Behaviour Change: A Literature Review

Louanne Keenan, RDH

University of Alberta

As health care providers, we have been supplied with the recommended protocol for the appropriate infection control procedures which are required to protect operators and their patients from contracting the HIV-virus. The Canadian Dental Association (CDA) issued national guidelines which state that the dental profession has an ethical and legal obligation to provide treatment to HIV+ patients. Since treatment of HIV+ patients is a responsibility of the dental hygienist, I have focused this literature review on the attitudes and feelings that health professionals experience when they are required to treat HIV+ and AIDS patients. Understanding the relationship between HIV-infected persons and those who interact with them may provide insights into population behaviour and a basis for determining how information may change values, attitudes and behaviour.

Support Our Exhibitors!

**Be sure to take time to visit the Commercial Table Clinic Display on Saturday, June 18th.
The Exhibit Hall will be open from 1:30 - 5:00.**

Alphabetical Listing of Commercial Table Clinics

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Dentsply (Hygiene Division)
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Numerous door prizes will be awarded throughout the afternoon; delegates must be in attendance to claim their prize.

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**On behalf of the CDHA Executive and Board sincere thanks is extended to the members of the
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A New Dental Health Initiative in British Columbia

By:
Vicki Thompson, RDH
Maxine Borowko, RDH, SDT, Cert VIT Ed

Introduction

Health care reform is sweeping across North America. Programs and initiatives are being developed to make health care more accessible and affordable. New partnerships and roles are evolving for many health care providers. The following article describes a program in British Columbia that is giving dental hygienists the opportunity to develop partnerships and to practise in a new way. The first part of the article focuses on the background and specifics of the program and the second part shares some personal perspectives and case summaries.

Background

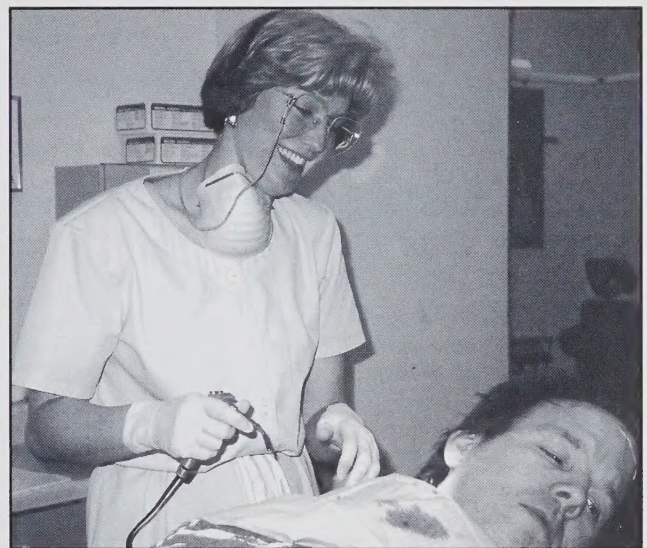
In 1981 the government of British Columbia made a commitment to integrate residents from Provincial institutions for persons with mental handicaps into the community. During the past twelve years much has been accomplished. More than one thousand individuals have moved from institutional settings to make their homes in the community. Less than four hundred individuals currently reside in provincial facilities. The population of adults with mental handicaps supported by the province is more than 4,500.

Personal growth and enhanced life experiences are the most exciting developments that have resulted from the downsizing initiative. While downsizing continues, a network of services and resources is developing in the community to support people with mental handicaps. This network includes residential services, training and education programs, social and financial assistance, employment projects and health care. Dental services were identified as an area requiring a specialized program to ensure individual needs are met.

Dental Health Services for People With Mental Handicaps

The Ministries of Health and Social Services initiated the Dental Health Services for People with Mental Handicaps Program (DHS/PMH) in January 1993. Five fulltime equivalent dental hygiene positions were established. Currently eleven provincially employed and two municipally employed dental hygienists, in consultation with Dr. E. Baja and certified dental assistant B. Bergen, serve adults with mental handicaps on a full or part-time basis through the DHS/PMH program.

The overall objective of the program is to achieve and maintain an appropriate level of oral health for this special client group. The DHS/PMH personnel work in collaboration with the client/caregiver/family and private dental practitioners to facilitate dental services in the client's community. Consultation with social workers, medical personnel, licensing officers and others is often required to accommodate the client's oral health care.



Kathryn Okada, RDH (private practice) with client Larry Wilcott in her office.

The dental hygienists are based in local health units throughout B.C. In the course of their duties they:

- assist clients and caregivers by developing daily personal preventive oral care plans in consultation with the client and caregivers.
- conduct dental in-service programs for care home staff, as required.
- provide an oral assessment screening examination for clients as appropriate.
- provide support and act as liaison between the residents, family, group home staff, local dentists, the dental consultant, community health and social service employees, to ensure that needed services are obtained.
- provide periodontal therapy to residents in their home or local dental office as appropriate, following an examination by a dentist.

- conduct dental education sessions for clients, family, support groups, various agencies and community colleges upon request.

Although the majority of the dental hygienists' time is spent conducting health education activities such as caregiver in-service training sessions and one-on-one skill enhancement sessions, the clinical and administrative aspects of dental hygiene practice are important aspects of this job as well. Opportunities to participate in research may occur in the future as the program becomes more established and issues requiring investigation become apparent.

The DHS/PMH dental hygienists, selected for their positions on the basis of their educational, experiential and personal attributes, participated in a training program early in their employment. They had the opportunity to learn first-hand from persons with mental handicaps, family members, advocacy representatives and other professionals during the five-day training session. The training program emphasized the service principles, values and philosophies established as the framework to guide government and service agency staff. The framework was developed to ensure the rights of individuals with disabilities are incorporated into the services provided in the community and that all individuals are treated in a respectful manner.

The training session also introduced the dental staff to the intricate network of government, community, and volunteer services, available in the community.



Vicki Thompson, RDH (DHS/PMH) with client Larry Wilcott in his kitchen.

Practical dental information was presented by Dr. Baja (Dentist), Betty Bergen (Certified Assistant) and Pauline Street (Dental Hygienist), all of whom have many years experience providing dental care for people with mental handicaps. Other presentations focused on seating, swallowing, and daily oral care considerations, education and networking strategies rounded out a very full week. The atmosphere throughout the training program was one of enthusiasm and commitment. The dental hygienists enjoyed the opportunity to get to know each other, to learn more about their new positions, and identify the contributions they could make.



Vicki Thompson, RDH (DHS/PMH) with client Ronald Alston and caregiver crew, doing clinical hygiene in Ronald's room.

Another continuing education program attended by the full time employees of the DHS/PMH program was the didactic portion of the Advanced Training Program in Dental Care of the Disabled (Decod) at the University of Washington in Seattle. The program was five full days of well-organized lectures and seminars. Presenters included: individuals with disabilities, clinical practitioners representing a variety of health disciplines and numerous medical and dental experts. The patient population addressed by the Decod program included individuals of all ages with disabling medical, physical, developmental, psychological, and sensory conditions.

Upon completion of the Decod program the dental hygienists prepared a summary of the information gained to share with their DHS/PMH colleagues. This is a routine practise for the DHS/PMH staff. There is so much to learn that by developing an information sharing network it has made working in this new and challenging area a little easier.

Knowledge may also be gained by sharing experiences. The following portion of this article shares the experiences of one of the full time dental hygienists of the DHS/PMH program. Vicki Thompson, in cooperation with some of her clients, their caregivers and community dental personnel has made progress towards achieving the goals of the program. The following summarizes some of the challenges and events that have occurred during the last six months for Vicki and a few of her clients.

A Personal Perspective

Within our communities there are a variety of associations and societies assisting people with residential and life skill needs. One such society referred me to a married couple who needed assistance. Agnes and Warren live independently in an apartment and receive twice weekly visits from a support worker. The support worker assists them with daily living activities. Living expenses (including dental expenses) are provided by the Ministry of Social Services. Warren uses public transportation to go to work. Agnes is a homemaker and enjoys her daily soap operas.

During my introduction to Agnes and Warren, they indicated they had been visiting their respective dentists on a fairly regular basis. Both had appointments made for the following month, but were unclear as to the purpose of the appointments.

Oral screenings were completed during my first visit to their home. I noted Agnes had very extensive oral problems including decay, periodontal disease and poor oral hygiene. Warren was worried about how he was going to use and care for the partial denture he believed he was going to receive at his next dental appointment. I accompanied both Warren and Agnes to their appointments to facilitate communication. The dentists they visited limited their practice to periodontics.

I discovered Warren had not understood the need to return to his general dentist for regular recalls. I was able to facilitate his return to the original general practice and will work with him to ensure his partial denture needs are met. The dental office personnel had missed Warren and had wondered why he had not been in for an appointment for some time. Working as a team we will help him obtain and maintain his partial denture. Keeping Warren on a regular recall will require sensitivity and awareness on the part of the receptionist and dental staff. Extra effort is required to make certain Warren is not lost "in the system" again.

Agnes requires a full upper denture. I will support her during the surgical appointments and provide for follow-up care in her home. Working with her social worker we arranged for a homemaker to visit and ensure Agnes follows post-operative instructions.

"The sights, sound and smells of a dental office are overwhelming for many people."

Agnes' comprehensive oral treatment needs require the combined efforts of many: one dentist provides for her periodontal and surgical needs, a denturist provides for her complete upper denture and another dentist will provide for her restorative needs. Not all practitioners are willing to take the time and effort to meet the needs of people who cannot cooperate fully. This situation did occur in Agnes' case which left us looking for a new denturist part way through the process. We are now back on track and optimistic that Agnes will adapt to her new dentures. During this process Agnes and I have become friends and I am privileged to enjoy her company and her trust.

Another example of a challenging and rewarding experience is my work with Susan and Rene, neither of whom have ever had dental treatment in a private dental office. In the past both received periodontal and restorative treatment in a hospital under general anaesthetic. The manager of the group home where they now live is committed to helping them find a dentist in their community. Was there anything I could do? I wasn't sure, as Susan and Rene would both open their mouth for me but only for two seconds. I decided to visit Sue regularly and slowly (very slowly) "teach" her to open her mouth and allow me access. She needed to get to know me and trust me. Over the next few months I visited Susan, at least twice a month, usually working in her bedroom. Progress was slow. Some days Sue would barely sit down, some days I could put a mirror in her mouth. I was elated the day Sue allowed me to floss her teeth. The next visit we were back to square one. Some days I felt frustrated, other days I left with a big grin on my face. Sue likes to show me her brushing skills and I have now included the caregivers, teaching them oral care techniques which may work well with Sue.

In the meantime, Rene became comfortable with my presence in their home and gradually accepted my attention. During this desensitizing process I was also scouting the area for a dentist willing to allow me time in an operatory and an accepting environment to assist Susan and Rene to learn about visiting a dental office.

Our goal is that eventually Rene and Susan will become part of the regular dental practice. I found a dental practice that was willing to cooperate, so arranged for an initial appointment. I admit I worried the night before, as Rene is very apprehensive about entering an office building. I had a vision of him refusing to even leave the van. I was at the dental office bright and early in order to be ready to greet them and their caregivers. Sue came rushing in, happy to see me waiting for her. Where was Rene? A second of doubt, then around the corner he peered, he saw me and came in. That was success enough for me.

Sue was willing to sit in the chair and even allowed me to perform a tiny bit of scaling. Next time I am confident we will accomplish more. Rene was more cautious and was content to sit and observe from a regular chair in the corner of the operatory. I was able to shine the dental light on him and dry brush and floss his teeth. Everyone — the caregivers, Dr. Wilkie, Rene and I were pleased, as we recognize this as a major milestone.

We will return for as many visits as necessary until we gradually reach the point where my services are no longer necessary, and Rene and Susan have their own community dentist. If they can attend regular preventive appointments, then the use of general anaesthetic may be unnecessary, or if it is still necessary to use general anaesthetic it may be once every 4 - 5 years, rather than yearly as it was in the past.

There has been another benefit of my work in the group home. Two other residents, who originally would not allow me to look in their mouth, now know me as the "teeth lady" and welcome me into their home. One fellow now gladly shows me his speedy brushing technique. Perhaps he will be next!

The sights, sound and smells of a dental office are overwhelming for many people. Imagine how intimidating and confusing this atmosphere is for a person with a developmental disability. Dental professionals endeavour to treat all patients with respect and compassion. Understanding individual differences helps prepare us to treat people appropriately. We hope that reading about Agnes, Warren, Rene and Susan has broadened your awareness of how people with mental challenges may be successfully cared for in a dental office.

Vicki Thompson received her diploma in Dental Hygiene from the University of Alberta in 1972. Past experience includes work in private practice, public health and a correctional facility. Currently Vicki is employed by the British Columbia Ministry of Health at the Boundary Health Unit.

Maxine Borowko received diplomas in Dental Therapy (1974) and Dental Hygiene (1984) from SIAST, Regina and a Certificate in Vocational Technical Education from the University of Regina in 1987. She has worked in public health, education private practice and long-term care. Maxine is currently employed by the British Columbia Ministry of Health.

Oral Pathology: Clinical-Pathologic Correlations (Second Edition)

Joseph A. Regezi, DDS, MS & James Sciubba, DMD, PhD, 1993, W.B. Saunders Company, A Division of Harcourt Brace & Company; The Curtis Center, Independence Square West, Philadelphia, Pennsylvania 19106

615 pages, including a 28 page Index, 5 page Table of Contents, 105 page "Clinical Overview" section, tables and illustrations/photographs too numerous to count

Reviewed by:

Barbara Ferris, Dip DH, BAC, BA and Barbara Drewry, Dip DH

This comprehensive oral pathology text is an important addition to any dental reference library. Although the information is very detailed and the terminology highly technical, it is organized with a clinical orientation that is extremely helpful for differential diagnosis.

The 19 chapters cover oral disease grouped by colour (white, red-blue, and pigmented lesions), tissue type (connective, salivary gland, and lymphoid tissue lesions), tumour types (odontogenic and non-odontogenic), cysts, inflammatory lesions,

malignant neoplasms, common lesions of the face, abnormalities of the teeth, dental caries and periodontal disease.

Each lesion is described first by *Etiology and Pathogenesis*, then by *Clinical Features*, followed by the *Histopathology* *Differential Diagnosis* and *Treatment and Prognosis* are also discussed in depth. Charts, tables and/or photographs appear on every page which helps to support the detailed information.

This text is very well organized with an extensive index, clear table of contents, and a current bibliography at the end of every chapter. A distinctive feature is the "clinical overview" found at the beginning of the book. This section follows the chapter headings and starts with a histological diagram, description and selected photographs of the condition, followed by a table summarizing the clinical features, causes, treatment and significance of various related diseases or lesions. Each condition is cross-referenced to the pages of the book where more detailed information may be found when needed.

Limitations of this text are that the photographs are not in colour, and that the terminology is highly technical. Students find that they need a colour atlas to accompany

the textbook, which adds to the cost, and they tend to get lost in the detail of the information therefore missing the important concepts. There are texts with much less detail which may be easier for students to understand when first studying oral pathology, however many educators feel that the strength of Regezi and Sciubba is its usefulness as a reference book *after* graduation, in clinical practice.

Indeed, its clinical categorization and charts are extremely useful for differential diagnosis in practice. There are lots of terrific photographs to help with identification of oral disease, but these are of somewhat limited value in black and white. The consistent layout of information in each chapter is useful for comparing lesions, as is the clinical overview section. Either for review, chairside reference, or comprehensive study, this text certainly accomplishes what the authors hoped it would, to "form a bridge between the didactic aspects of oral pathology and the practical clinical considerations".

CDHA's Book of the Month Suggestions

May:

***Working Ourselves to Death —
The High Cost of Workaholism and
the Rewards of Recovery***

Diane Fassel, PhD

Harper, San Francisco, 1990

ISBN 0-06-254869-7 (soft cover)

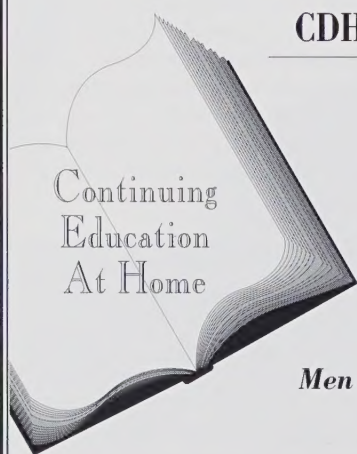
June:

***Men are from Mars, Women are from Venus
A Practical Guide for
Improving Communication and
Getting What you Want in Your Relationships***

John Gray, PhD

HarperCollins, 1992

ISBN 0-06-016848-x (hard cover)



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Summary of prescribing information

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Indications

"Tantum" Oral Rinse is indicated for relief of pain in acute sore throat and for the symptomatic relief of oropharyngeal mucositis caused by radiation therapy.

Contraindications

"Tantum" Oral Rinse is contraindicated in subjects with a history of hypersensitivity to any of its components.

Precautions

The use of undiluted "Tantum" Oral Rinse may produce local irritation manifested by burning sensation in patients with mucosal defects. If necessary, it may be diluted (1:1) with lukewarm water. Since "Tantum" Oral Rinse is absorbed from the oral mucosa and excreted mostly unchanged in the urine, a possibility of its systemic action has to be considered in patients with renal impairment.

Use In Pregnancy

The safety of benzidine HCl has not been established in pregnant patients. Risk to benefit ratio should be established if "Tantum" is to be used in these patients.

Use in Children

Safety and dose directions have not been established for children five years of age and younger.

Adverse Reactions

The most frequent adverse reactions reported are: local numbness (9.7%), local burning or stinging sensation (8.2%), nausea and/or vomiting (2.1%). The least frequent were reports of throat irritation, cough, dryness of the mouth associated with thirst, drowsiness and headache.

Treatment of Overdosage

There are no known cases of overdosage with benzidine HCl gargle. Since no specific antidote for benzidine is available, cases of excessive ingestion of the liquid should receive supportive symptomatic treatment aimed at rapid elimination of the drug.

Dosage and Administration

Acute sore throat: Gargle with 15 mL every 1 1/2 to 3 hours keeping in contact with the inflamed mucosa for at least 30 seconds. Expel from the mouth after use.

Radiation Mucositis: Use 15 mL as a gargle or rinse repeated 3-4 times a day, keeping in contact with the inflamed mucosa for at least 30 seconds and then expel from the mouth. Begin "Tantum" Oral Rinse the day prior to initial radiation therapy; continue daily during the treatment and after cessation of radiation until the desired improvement is obtained.

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Product monograph is available on request.

References:

1. Simard-Savoie S and Forest D. *Curr Ther Res* 1978; 23(6):734-45.
2. Whiteside MW. *Curr Med Res Opin* 1982; 8:188-9.
3. Wethington JF. *Clin Ther* 1985; 7(5):641-6.
4. Product monograph.
5. Yankell SL. Evaluation of benzidine HCl in patients with aphthous ulcers. *The Compendium of Continuing Education* 1981; 11(1).
6. Epstein JB. *Int J Radiation Oncology Biol Phys* 1989; 16(6):1571-5.

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STUDENT SCENE

The following is an abstract of an article that gives insight and definition to current oral health issues in Community Health.

Frazier, P. Jean; Research on Oral Health Education and Promotion and Social Epidemiology; J. Public Health Dent. 1992; 52(1), pages 18-22

This article describes the paradigm shift from the traditional approach to the prevention of oral disease using the medical model based on disease as an isolated incident, to the integrated holistic approach to the promotion of health as a sociological phenomenon. The definitions of concepts such as primary prevention, health education, health promotion, social epidemiology, evaluation and monitoring provide the context for the argument of this approach to public health. The involvement of the community in decision-making where self-determination is key in program developing is based on the public health model.

Understanding human behaviour determinants underlies this approach to health planning within a multidisciplinary team. Rather than 'promoting behaviors' this approach aims to increase knowledge in the population which then forms the basis of informed consent. (The article acknowledges that broad scale research is required to assess the methods used to measure knowledge, attitudes and beliefs, particularly in the context of health promotion activities.) The difficulty of investigation which can be easily evaluated but seems to have limited long term success is also acknowledged.

The article identifies numerous oral health issues requiring immediate attention. These include: informed consent, sealants, oral health practices, beliefs and knowledge of oral health professionals, development of participatory educational strategies, public knowledge of fluoride as well as research on fluoride use. It is argued that a better informed public could forestall the tactics of anti-fluoridationists. Being proactive about oral health, through knowledge, is the basis of this immediate concern.

Specific areas of research are outlined in point form under the headings: social epidemiology which includes sociodental and

dentofacial areas of study; health education which includes assessing materials and sources in a myriad of possible areas of study; health promotion would look at a variety of integration techniques; and also the development of evaluation and monitoring techniques.

The formation of cooperative partnerships in education, professions and agencies is necessary, following up with workshops to encourage those involved in public health to take initiatives to integrate oral health into overall health education and health promotion activities.

The concluding paragraph is the key to the future of effective oral health promotions. It states:

Conceptual development is required in the field of oral health education and promotion in dental public health practice, using the public health model of health education and definitions of health education and health promotion that are universally accepted by researchers in other health content areas. Research is required to establish and test community development strategies designed to foster a more participatory approach to decision-making about the uses of preventive programs.

*submitted by Mary Findlay
a Dental Hygiene student enrolled in the
Dental Hygiene Degree Completion program
at the University of British Columbia*

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The American Dental Hygienists' Association invites all members of the health professions to participate in its Third Dental Hygiene Research Conference, *Professional Growth Through Research*. The conference will be held August 4-7, 1994 at the Minneapolis Marriott City Center Hotel in Minneapolis, Minnesota. To register or get more information please call Maria Maloney (312) 440-8931 at ADHA Professional Development, 444 N. Michigan Avenue, Suite 3400, Chicago, IL 60611 FAX 312/440-8929.

Join your colleagues while you review new oral health care research. Learn how to conduct research and incorporate others' new research findings into your own practice.



Preliminary Schedule of Events at Minneapolis Marriott City Center Hotel

THURSDAY, AUGUST 4, 1994

9:00-2:15 PRECONFERENCE WORKSHOP
"How to Be a Successful Grant Writer"

EVENING Welcome RECEPTION

FRIDAY, AUGUST 5, 1994

9:00- 9:30 Opening Ceremony

9:30-10:30 KEYNOTE SPEECH Marcia Brand, RDH, PhD
Allied Health Specialist, U.S. Public Health Service
"Allied Health Professionals: Hidden Assets"

10:45-12:00 National Dental Hygiene Research Agenda

12:00- 1:30 LUNCH PROVIDED

1:30- 2:15 A Research "Vision"

2:15- 3:00 Embracing the Research Agenda

3:15- 4:30 Implementing the Research Agenda

SATURDAY, AUGUST 6, 1994

8:00- 9:30 POSTER SESSIONS

9:45-12:00 NATIONAL ISSUES FORUM

12:00-1:45 LUNCH & LEARN — ROUNDTABLE TALKS

2:00- 5:00 SCIENTIFIC PAPERS

5:15-11:00 Evening Outing Visit **Mall of America**

SUNDAY, AUGUST 7, 1994

8:00 - 12:00 PUBLIC HEALTH INDEX WORKSHOP

8:00 - 9:45 SPECIAL INTEREST SESSIONS I

- Designing a Research Course
- Initiating a Research Project
- Information Resources: New Developments to Aid Literature Searching

SUNDAY, AUGUST 7, 1994 (continued)

10:00-11:45 SPECIAL INTEREST SESSIONS II

- Mentoring Student Research
- Protection of Animals and Human Subjects
- Design Principles for Clinical Trials

12:00-1:00 LUNCH PROVIDED

1:00-3:00 PRECONFERENCE WORKSHOP ENCORE

- Priorities for Allied Health Professions
- Grants Management

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US \$100 Conference fee for full-time dental hygiene students

US \$225 Conference fee for non-members

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Northwest Airlines is offering conference attendees a 10 percent discount off unrestricted coach fare and five percent off the lowest applicable fare in Canada and the U.S. Centrally located, Minneapolis offers minimal travel so most Canadians and Americans may attend.

Minneapolis, renowned for pleasant summers with an average August temperature of 27 degrees C, offers theater, music, museums, outdoor activities and ethnic restaurants. Mall of America, the largest indoor playing, eating, entertaining, shopping center in the nation, is located nearby. Downtown Minneapolis boasts 22 lakes and 153 parks woven together by a 45-mile system of paved paths.

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Please complete and return this registration form with payment to 1994 Research Conference, ADHA, Professional Development, 444 N. Michigan Ave., Ste 3400, Chicago, IL 60611, or FAX to 312/440-8929. To receive the **EARLY BIRD DISCOUNT**, your registration must be postmarked by **JULY 8, 1994**. Registration received after July 8th will be processed on site. Registration fee covers all conference sessions plus reception, breaks, daily lunches and final proceedings. Make checks payable to ADHA.

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NOTE: Through the generous support of the ADHA Institute for Oral Health, the first 125 full conference registrants may attend the pre-conference workshop, "How to Be A Successful Grant Writer" **FREE-OF-CHARGE**. You may attend the preconference workshop on August 4, 1994 for \$75 even if you choose not to attend the full research conference August 5-7, 1994.

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SOCIAL EVENT Saturday, August 6 from 5:15-11:00 p.m.

☐ Mall of America US \$ 12 \$ _____

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SIGNATURE: _____ EXPIRATION DATE: _____

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LUNCH AND LEARN: Please mark your top three choices by placing 1,2,3, by these Lunch and Learn topics. These discussions will take place during the daily lunches included in the registration fee. These topics are preliminary. Some topics may not be offered.

- | | | | |
|--|--|---|---|
| ☐ Access to care | ☐ HIV Patients | ☐ Pain control | ☐ Disease prevention |
| ☐ Fluorides | ☐ Occupational injury | ☐ Cultural Diversity | ☐ Microbiology |
| ☐ Mouthrinses/
anti-microbials | ☐ Caries control | ☐ Interpersonal
communication | ☐ Salivary Research |
| ☐ AIDS | ☐ Implants | ☐ Periodontics | ☐ Ethnographic
Research |
| ☐ Gerontology | ☐ Oncology | ☐ Dental aesthetics | ☐ Minority populations |
| ☐ Alternative Practice | ☐ Chairside Diagnostics | ☐ Radiology | ☐ School oral health |
| | ☐ Infection Control | | |

		<i>SPONSOR</i>	<i>LOCATION</i>	<i>FOR INFO CALL</i>
May 1994				
13-14	North Coast Spring Meeting	Greater Cleveland Dental	Cleveland, OH	(216) 573-1181
14	Recognizing Periodontal Infection and Selecting Treatment – Dr. Esther Wilkins	Northern Alberta Dental Hygiene Society	Edmonton, AB	(403) 439-7016
14	Infection Control – Heather Bowers, RDA – Cathy MacLean, BN	Dalhousie University	Halifax, NS	(902) 494-1674
14	Infectious Diseases and Infection Control	University of Western Ontario	London, ON	(519) 661-3902
18-20	Root Planing Therapy A Participation Program – Prof. J.F.L. Pimlott	University of Alberta	Edmonton, AB	(403) 492-5023
28	Current Issues & Insights in Dental Hygiene: A Professional Exploration Day for Dental Hygiene	University of Toronto	Toronto, ON	(416) 979-4900
28	Treatment Options for the Partially Edentulous – Dr. Crawford Bain	Dalhousie University	Halifax, NS	(902) 494-1674
June 1994				
3-4	Clinical Head and Neck Gross Anatomy – Dr. Geoff H. Sperber	University of Alberta	Edmonton, AB	(403) 492-5023
4	Hands-On Workshop with Jenny Thomas	Kingston & District Component of ODHA	Kingston, ON	(613) 531-8462
4-10	Orthodontic Module for Certified Dental Assistants and Registered Dental Hygienists Presented by Members of the BC Society of Orthodontists and Certified Orthodontic Assistants	University of British Columbia	Vancouver, BC	(604) 822-2626
10	Clinical Periodontics for Dentists & Dental Hygienists (Part I)	University of Western Ontario Faculty of Dentistry	London, ON	(519) 661-3902
11	Clinical Periodontics for Dentists & Dental Hygienists (Part II)	University of Western Ontario Faculty of Dentistry	London, ON	(519) 661-3902
17-19	CDHA Annual Professional Conference	Canadian Dental Hygienists Association	Saskatoon, SK	(613) 728-8730
18	Clinical Periodontics for Dentists & Dental Hygienists (Part II)	University of Western Ontario Faculty of Dentistry	London, ON	(519) 661-3902
July 1994				
8-10	World Conference for Oral Health	The Organizing Committee of The World Conference for Oral Health	Tokyo, Japan	81-3-3508-1214
August 1994				
4-7	American Dental Hygienists Association Research Conference	American Dental Hygienists Association	Minneapolis, MN	(312) 440-8931
12-14	Restorative Dental Hygiene Refresher Course – Debbie Daniels, RDH	George Brown College/CDHO	Toronto, Ontario	(416) 928-1302
19-21	Restorative Dental Hygiene Clinical Refresher Course	George Brown College/CDHO	Toronto, Ontario	(416) 928-1302



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Current Techniques and Philosophies of Root Planing and Ultrasonic Instrumentation

- When we root plane a difficult periodontal patient, what are our objectives?
 - to secure a biologically acceptable root surface
 - resolve inflammation
 - reduce probing depths
 - improve or maintain attachment levels
 - reduce or sometimes eliminate need for pocket reduction surgery
 - all of the above.
 - Which statement is **FALSE** in regards to current philosophies of root planing?
 - root planing is a definitive treatment procedure designed to remove cementum or surface dentin that is rough, impregnated with calculus, or contaminated with toxins or microorganisms
 - root planing is instrumentation of crown and root surfaces, primarily supragingivally, to remove plaque, calculus and stain
 - when root planing is done in a thorough manner, some unavoidable soft tissue debridement occurs from the inside of the pocket wall
 - a true root planing stroke is a long overlapping "shaving" type of stroke, extending from the base of the pocket to the cemento-enamel junction
 - root planing is a process by which residual calculus and portions of diseased cementum or dentin are removed to produce a smooth, hard, clean root surface
 - In which of these cases is an ultrasonic instrument such as a cavitron **NOT** useful prior to root planing?
 - on a patient where plaque is present on 85% of tooth surfaces, and gingival tissues are fibrotic and firm
 - where there is heavy, supramarginal calculus in a "few isolated areas"
 - where a patient presents with Class II furcation involvement on four mandibular molars, and an average probing measurement of 8mm
 - where a patient presents with two recent guided tissue regeneration (GTR) sites and two new implants
 - on a maxillary first premolar, bifurcated with the mesial surface presenting with a deep developmental groove, extending from bifurcation to crown
 - Which of the following is **INCORRECT** regarding precautions while using a cavitron?
 - operator should ensure patient's medical history does not contraindicate use of an ultrasonic instrument. (i.e.) history of Hepatitis B; presence of a pacemaker
 - both operator and patient should wear protective eyewear
 - patient should rinse first with an antimicrobial agent, such as Chlorhexidine to reduce oral bacterial count in aerosol
 - if patient is not anesthetized and has minimal pocket depths, cavitron power setting should be turned to the highest setting to ensure patient's comfort
 - Why is it superior on a severely periodontally involved patient, to cavitron and root plane each quadrant to completion, rather than full mouth gross scale with the cavitron alone, on the first appointment?
 - there is little danger of promoting abscess formation
 - insertion of the instrument's working end is easier on untreated teeth in subsequent appointments
 - the hygienist is engaged in removal of heavy to moderate deposits and true root planing at each appointment, providing for more variety, therefore less operator fatigue
 - hygienist and patient can compare and sometimes "see" results of treated versus untreated quadrants of the mouth
 - all of the above
- Are the following statements **TRUE** or **FALSE**?**
- Much debate is still out over hand instrumentation alone versus ultrasonic instrumentation alone.
 - Root planing can be contraindicated in a periodontally healthy area, since it has been established that shallow sites (2-3mm) can actually "lose" attachment with this therapy.
 - Root planing is less predictable in pockets 5mm and greater, and within furcations; yet, still valuable in decreasing inflammation and bacteria by inducing tissue biochemical changes.

- Minimal pocket reduction occurs after irrigation (with Chlorhexidine, for example), as a monotherapy, whereas when root planing precedes irrigation there is a greater reduction of pocket depth.
- The ultrasonic instrument may be an effective system to mechanically remove plaque and calculus, while at the same time deliver a chemotherapeutic agent.
- Scalers, files, hoes, gracey's, columbia's and hartzell's are all examples of root planing instruments.
- Root planing does not seem to induce shifts in the composition of the subgingival microflora.
- Recent studies show that there is a greater amount of root "softness" rather than "hardness" after hand instrumentation, but even less with a cavitron, and the least, amount of root softness after use of a piezoelectric ultrasonic instrument.
- Piezoelectric instruments are possibly affecting the root surface the least negatively, since it vibrates at 25,000 cycles a second, versus the more conventional cavitron which vibrates at around 45,000 cycles a second.

Answers:

1. f)	2. b)	3. d)	4. d)	5. e)	6. T	7. T	8. T	9. T	10. T	11. T	12. F	13. T	14. F
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This self assessment test was written and prepared by Bonnie L. Chetner, BSC, RDH. Clinical Instructor, Division of Dental Hygiene, University of Alberta; Periodontal hygienist, Edmonton, Alberta

Reference list available upon request.

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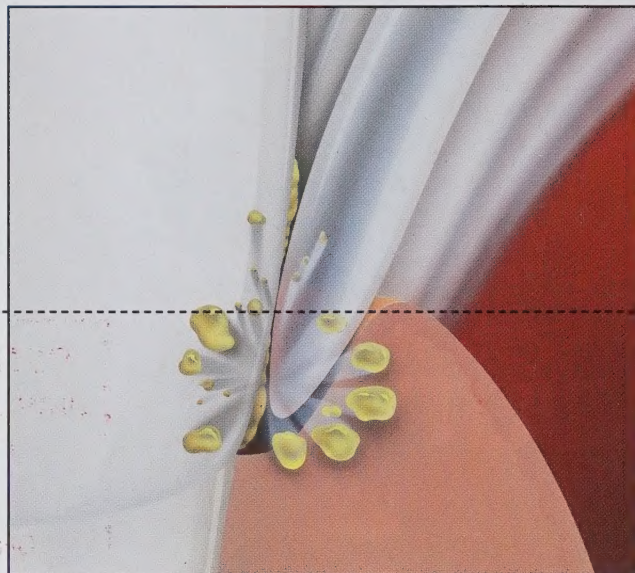
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PROBE



VOL 28, NO 4

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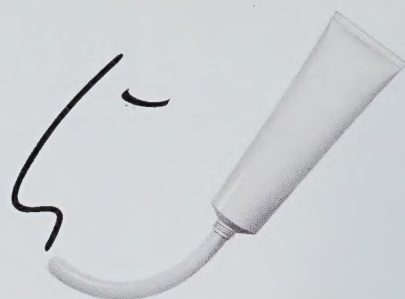
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The World Moves On

I can't seem to start this editorial; usually my keyboard is burning to get all my thoughts out to you and I'm jockeying for additional space to allow for all my ramblings. This time it's different; this is my last editorial as scientific editor of *Probe*. I find it difficult to say good-bye.

Five years is long enough for something to become an inextricable part of your life. Every time I pick up any sort of "glossy" I am leafing through it looking at headers and print and layout and articles and items of interest. Each conference I go to I am looking for potential authors and topics and new information. Each time I am at a dental hygiene gathering I am scanning the crowd to see who could contribute in some special way (maybe now I will be able to attend these things without people cutting a wide swath about me!). The journal has become woven into every thread of my dental hygiene fiber and I cannot give it up without part of my own fabric being torn away.

When Fran handed me the reins back in '89 I was scared to death. There was no editorial board, no copy editor, no managing editor; just our Executive Director, Carol Worobey and myself. We solicited authors, counselled authors, edited authors, reviewed, sent out for review, wrote and re-wrote items (even created items when articles were late), filled in "white space" and read, read, and re-read every issue until we could each recite the whole journal verbatim!!

The journal always seemed to get out to you, the members, with no blank pages, a minimum of typos, and hopefully some good information. As we grew, Elizabeth came on to handle copy editing and the editorial board came together to offer constructive critique. Now, we even have a bona fide statistician for statistics review!

As our baby began to grow we gathered a series of contributing editors, Carol being the most current, Dianne, our Editorial Director and now Janice, our Director of Communications. I must not forget to mention our vast team of anonymous reviewers, without whose help we would not hold the distinguished position of a "peer reviewed journal".



MARILYN GOULDING, RDH, BSc

Time marches on and now we evolve to the next step, a whole re-structuring of the scientific editor's position to a region-based design. I should be rejoicing; what with teaching dental hygiene full time and now taking my Masters Degree the extra time should, and will, be appreciated. Still, it's the end of a chapter; not just for me but for the journal as well.

New people will mean new ideas, new visions, and new directions. The challenge for the new structure will be to ensure that changes are made in an "evolutionary-positive" direction. The person at our "communications helm" will maintain the scheduled day to day operations while the Editorial Director and Editorial Board (of which I am now a member) will keep their hands on the heart of dental hygiene, sensing its every beat as accelerated growth causes periods of palpitation and even momentary cessation when changing legislation throws us its curves.

Glancing back at the beginning of my term I was so enthusiastic and confident in my direction. If only I had realized how little I really knew I would have run the other way! You never know how to do a job when you first begin, regardless of your qualifications. Each new position brings with it its own unique personae. But you learn, with each faux pas and with each victory until, over time, you

begin to know what you're doing. There even comes a time when you catch up to the position and you and your job grow together. As I leave the journal I can safely say that now I know what's involved in being a good scientific editor (but only to a dental hygiene journal of this particular size and scope). Put me in a new job or give me a new journal and I'd be fumbling along just as I did when I first came to *Probe*.

There's a lesson to be learned even in this; nobody in a new position really knows how to do it; you can never be completely prepared. So say yes and take on jobs when they become available. You will learn how to be good in your position and the compensation will be more than any dollar value you could attach to it. I promise you will grow in wisdom and maturity, in skill and in insight. You will steel yourself against constructive criticism, rejoice in supportive words and feel the satisfaction of accomplishment. You will collect travel miles, visit many parts of Canada, make dear friends and be left with more fond memories than any one lifetime can hold.

Thank you all for trusting me with guardianship of your journal. (I leave with a "Probe-shaped" hole in my heart!) It's been a real source of pride and honour for me these past five years.

But wait, I think I hear a call to be re-cycled; some new challenge in the wind?? Perhaps you haven't seen the last of me yet!

*"Few will have the greatness
to bend history itself;
but each of us can work
to change a small portion of
events, and in the total
of all those acts will be written
the history of this generation."*

— Robert F. Kennedy —

National Dental Hygiene Campaign

The National Dental Hygiene Campaign is the responsibility of CDHA's Health Promotion Council.

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COVER

This issue's cover features Catherine Thom, Dip DH, MA and several dental hygiene colleagues battling rough waters. After graduation from the University of Toronto in 1967, Cathy gained experience in general and orthodontic specialty practices.

Since joining the faculty of Algonquin College in June 1974 Cathy has worked in the dental assistant and dental hygiene program in a number of different capacities. Upon completion of her Master's degree in Social Psychology at Carleton (1985) she embarked on a project to research and implement the dental hygiene testing procedures which are now used by all Ontario Colleges for selection of dental hygiene students into English language programs.

OFC — 1—Carole Ono, 2—Linda Ewart, 3—Lynn James, 4—Mary Bondarchuk

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L'Association Canadienne des Hygiénistes Dentaire

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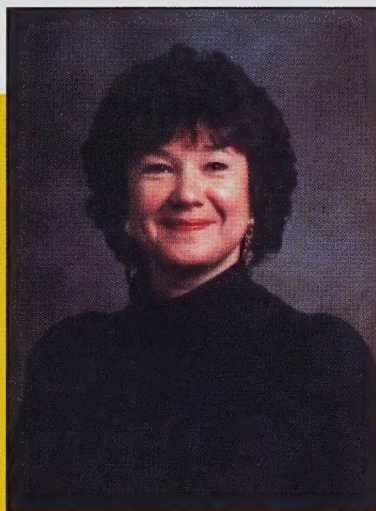
The first thing I would like to say to CDHA members is "thank you". Thank you for allowing me to have the privilege of representing you as CDHA President. In fact, for me this role is much more than a privilege, it is interesting, exciting and fun. I highly recommend you get involved with your professional association. Whether at the component, provincial or national level, the opportunities for professional and personal growth and gratification are endless.

The second thing I would like to share with CDHA members is a little information about myself. I think an introduction might be helpful because for the next five issues of *Probe* you will be exposed to some of my thoughts and opinions on various topics concerning the dental hygiene profession. Knowing a little of my background may make those thoughts and opinions more understandable. I would also like you to feel you know the President of your national association, at least a little.

I sincerely hope some of you will feel motivated to write to me and share a little about yourself, your thoughts and opinions after reading this message. I know I've already suggested that dental hygienists get involved with their professional associations because I believe our associations are prime vehicles for information-sharing and the initiation of action. However, if getting involved with an association isn't convenient and you want a speedy route to CDHA's Executive, then send your ideas directly to me. Does the phrase "I wonder why they don't do....." come to mind when you think of CDHA? If it does, wonder no more, take action instead. We may not be doing..... for a good reason or perhaps the idea has simply never occurred to us. That's how *you* can make a difference. By sharing your ideas and suggestions we'll discover what you think and how you feel about what we are doing. The mail box is always open!

Now back to the introduction. I won't bore you with what a wonderful baby I was but I do want to start more than twenty years ago, in 1972 to be exact. In 1972 I was accepted into the first class of dental nurses (now called dental therapists) at Wascana Institute of Applied Arts & Science (now called Saskatchewan Institute of Applied Science and Technology) in Regina (still called Regina!). This opportunity came after two years of 'post high-school agonizing' as I tried to decide what I was going to be "when I grew up". (If nothing more, those two post high-school years taught me that banking and clerking were definitely out!)

I loved dental therapy from the beginning. In 1972 dental therapy was not only a new profession



**MAXINE BOROWKO,
RDH, SDT, CERT VIT Ed**

in Saskatchewan, it was new to North America; and although it met with a lot of opposition from dentistry it thrived in spite, and some might argue *because* of it. An exciting sense of mission and camaraderie motivated dental therapists then, and continues to do so now. Saskatchewan dental therapists, as you may be aware, were originally introduced in Saskatchewan and Manitoba to provide for the preventive and restorative needs of children. The majority of dental therapists were initially employed in school-based public health programs. (Not to be confused with federal dental therapists who were at the same time being educated in Fort Smith, NWT to provide dental services in many northern and remote communities across Canada.)

Much has changed for dental therapists in recent years, and that's an article in itself. Suffice to say my education, employment and association involvement as a dental therapist has had a definite impact on my views. My experiences as a dental therapist have influenced my views on self-regulation, supervision, practice settings, economics, politics, health education, health promotion and more.

In 1984 I graduated from the dental hygiene program at SIAST, another experience that dramatically influenced my views while increasing my qualifications. A Dental Hygiene diploma gave me opportunities I had never had before. For this I am grateful, as are many other dental therapists who have broadened their knowledge, skills and opportunities with a dental hygiene education.

In 1987 I received a Certificate from the University of Regina in vocational/technical education. Through this program I developed a better understanding of adult learners and adult education. That program, too, has affected how I view events and options today.

During the past ten years dental hygiene has afforded me numerous exciting and challenging opportunities. I have had the benefit of working in private practice, education, long-term care hospitals and community health. I have also had the pleasure of participating in two provincial dental hygiene associations (Saskatchewan and British Columbia) and the CDHA. What's even more exciting and challenging are the opportunities yet to come, not just for me personally, but for the profession as a whole. I'm confident the wedge is in the door and more opportunities for us to improve the health of Canadians is on the horizon. Dental Hygiene will become part of the growing multidisciplinary approach to health care. We will continue to work as partners within the current dental model, but we will also contribute significantly to bridging the gap that has separated dental care from medical care throughout history.

The Dental Hygiene profession has been built upon many of the concepts and themes that are fueling health care reform across North America. Although we don't have a monopoly on priorities such as prevention, health education and health promotion we certainly have the education and experience to take these priorities into a variety of new settings and to new clients.

I can see my introduction is turning into a soap box address of sorts, but I'm not apologizing — my hopes and aspirations for future roles for Dental Hygienists are part of 'the me' I want you to know.

An introduction wouldn't be complete if I didn't tell you a little about my personal life too. (Nothing juicy mind you!) I am married to a very supportive man, Gary, and we are blessed with two daughters Whitney (14) and Lindsay (12) and a dog and a horse. Our home, an old farm house, is situated on a small acreage in Maple Ridge, BC and although I still miss Saskatchewan, we love our lives in BC.

Before closing let me remind you that I really would like to get to know all of you better over the next year. I want to hear about your hopes, dreams and ideas as they relate to the dental hygiene profession. Jot me a note when you feel the urge and thanks again for this special opportunity to represent you on the CDHA Board. It is indeed a pleasure to work with so many talented and dedicated people.



Oral Health Day Celebrations

Fraser Valley Dental hygienists celebrated Oral Health Day (April 7) with a cake-cutting ceremony. They were also celebrating the milestone decision

made by Health Minister Paul Ramsey which confirmed British Columbia will establish a College of Dental Hygiene to regulate the profession.



(l-r) Dani Brisbin (Past President, Upper Fraser Valley Dental Hygiene Society UFVDHS), Gaye Somers (Secretary, UFVDHS), Maxine Borowko (President, CDHA), Vicki Thompson (President-Elect, BCDHA), Paula McAleese (President, UFVDHS)

PEI Dental Hygienist Awarded Life Membership in PEI Home and School Federation

CDHA Member Audrey Newcombe was awarded Life Membership in the Prince Edward Island Home and School Federation this spring. Federation Executive Director, Shirley Jay, presented the award at the federation's Annual Meeting held in Charlottetown in April. Newcombe, a member of CDHA's Member Services Council, served as president of the PEI Home and School Federation for two years. In late May, Newcombe was appointed to the Maritime Core Curriculum Committee. This committee develops core curriculum for elementary, junior and senior high schools for the Maritime provinces.

According to Jay, Newcombe helped move the organization to a place of equality and respect within the educational community. "This is due largely to her tremendous leadership abilities — her insight which allows her to cut to the heart of a matter, her fluency of expression, her willingness to listen to and learn from those around her and, probably of most importance her personal integrity because it has never wavered or diminished."

Jay says Newcombe is counted on and admired because she has always taken on more than her share of responsibility and never backs away from a challenge.

Dental Hygiene Training Debuts In New Zealand

Dental Hygiene Instructor, Gail Lightfoot of Dunedin, New Zealand says the initiation of a Dental Hygienist Training Program at Otago Polytechnic is a landmark development in the country's dental history. The school is offering a National Certificate in Dental Hygiene for the first time ever this year, and the program will be administered by the school's Department of Nursing and Midwifery. According to the course prospectus, Otago Polytechnic is "the only institution in New Zealand with New Zealand Qualifications Authority (NZQA) accreditation for this course".

Otago Polytechnic is one of New Zealand's leading tertiary learning institutions and offers a broad range of Degree, Diploma, and Certificate courses to both New Zealand and International students. The Prospectus notes that individuals trained to become Dental Hygienists in the program "will be part of the advent of a whole new profession and qualification to New Zealand." The certificate program was developed by the New Zealand Dental Association and will enable applicants to complete the requirements of the New Zealand Dental Council to practice as qualified Dental Hygienists. Course subjects include introduction to dentistry, diet and nutrition, communication skills, physiology, anatomy, pathology, dental health education, oral anatomy and oral biology, oral pathology and oral medicine, pharmacology, clinic management, preclinical practice, radiography, dental casts and clinical practice experience. The course is structured so that approximately 50% of the time is spent on theory and 50% of the time is devoted to clinical practice. The course is a full-time three semester program. The first two semesters are sixteen weeks in length each and the third semester is twelve weeks long.



CDHA member, Audrey Newcombe, was honoured for volunteer efforts in her community.

Canadian Dental Hygienist Appointed to US Research Advisory Panel



Dental hygiene educator and active CDHA member, Ellen Brownstone, is one of 27 members appointed to sit on a US National Advisory Panel devoted to developing a National Dental Hygiene Research Agenda

and a Centre for Dental Hygiene Research in the United States. She is the only Canadian appointed to the panel.

The panel was struck following receipt of a grant from the US Bureau of Health Professions and is part of an effort to develop, implement and evaluate the development of a National Centre for Dental Hygiene Research. It is hoped this centre will be used as a prototype for other allied health disciplines.

The project, "A Model to Link Dental Hygiene Practice and Education through Collaborative Research Training Centres" is based on a collaborative research model that links dental hygiene clinicians, educators and researchers in order to expand and strengthen the oral health care research base. The project was developed through the joint efforts of JoAnn Gurenlian, RDH, PhD (former Chair of the Department of Dental Hygiene at Thomas Jefferson University), Jane Forrest, RDH, MS (principal investigator), and the Directors of the Centre for Collaborative Research, Kevin Lyons, PhD and Laura Gitlin, PhD.

IADR Forms Oral/Dental Hygiene Research Group

Dental hygiene researchers will be pleased to learn there is now an international forum to present their work within. The International Association of Dental Research (IADR) accepted a proposal put forth by the International Federation of Dental Hygienists (IFDH) to develop an Oral /Dental Hygiene Research Group. Professor Ellen Brownstone of the University of Manitoba's School of Dental Hygiene and CDHA's IFDH Junior Representative says that the creation of this group will give dental hygienists opportunities to collaborate and network with other researchers outside of the discipline of dental hygiene. "The presence of dental hygiene researchers in IADR will contribute to dental hygiene's professionalization and growth," she adds.

New Mexico Achieves Self-Regulation

A report in the American Dental Hygienist's Association's publication, *Access*, announced the passing of a milestone in the United States' dental hygiene history. According to the article, in February New Mexico became the first state to establish *genuine* self-regulation for the profession. It noted that the state's self-regulation bill was unanimously approved by the senate, barely a week after sweeping the house with only one dissenting voice.

The report also said that "the dental hygiene committee to be appointed in New Mexico will have the power to promulgate rules and formulate

regulations related to dental hygiene practice that the dental health board will be compelled to ratify." And furthermore, the language of the bill clearly specifies that the dental health board may only govern the licensure, examination, and regulation of dental hygiene "through the dental hygiene committee".

New Mexico's Dental Hygiene Association has been working to achieve self-regulation for more than a decade.

Past President of American Dental Hygienists Association Appointed to National Commission on Allied Health

Deborah Bailey McFall, RDH, BS was appointed to the United States' National Commission on Allied Health of the Health Resources and Services Administration. The purpose of the Commission is to provide advice and make recommendations to the Secretary of Health and Human Services, the Committee on Labor and Human Resources of the Senate and the Committee on Energy and Commerce of the House of Representatives. The Commission makes recommendations and provides advice to these groups on a comprehensive spectrum of issues, problems, and solutions pertaining to the education, supply and distribution of allied health personnel throughout the United States.

RDH Pins Available

CDHA receives numerous inquiries about the availability of RDH pins. We are pleased to advise members that these items are being offered for sale by the New Brunswick Dental Hygienists Association. The pins sell for \$10 a piece and if more than ten are ordered at one time the price is \$9/pin. To place your order, call

Sharyn Milroy at
(506) 384-1961 or write to her at
85 Oakmoor Terrace,
Moncton, NB E1G 1T4.



American Dental Hygienists Association to Host Research Conference

The American Dental Hygienist's Association (ADHA) will host its third annual dental hygiene research conference August 4-7 in Minneapolis, Minnesota. The conference will feature Marcia Brand, RDH, PhD, of the Bureau of Health Professions with the United States Department of Health and Human Services. Brand will deliver a presentation entitled "Allied Health Professionals: Hidden Assets". Meeting highlights include a national issues forum, special interest sessions, scientific presentations and an introduction to ADHA's new National Dental Hygiene Research Agenda.

Canadian Nurses Celebrate National Nursing Week

Thousands of registered nurses celebrated National Nursing Week, May 9-15 by organizing activities to illustrate the 1994 theme, *Nurses Make the Difference*. According to Fernande Harrison, President of the Canadian Nurses Association (CNA), nurses are positioning themselves at the forefront of the evolution of health care in Canada by shifting the emphasis of health-care delivery toward consumer involvement, community services, disease prevention and health promotion. "Their innovative and preventive approaches in developing and implementing cost-effective programs result in substantial savings and high client satisfaction," she adds.

According to Harrison nurses are increasingly mobilizing "healthy community" projects and working with families to identify problems, develop solutions and educate about preventive health care. More and more they are becoming the entry point into the health-care system.

Canadian Dental Hygienists are moving in a similar direction. As more provinces achieve self-regulation the profession is being positioned to help increase access to care and focus on prevention in alternate practice settings in collaboration with other health care professionals.



First Canadian Conference on International Health (CCIH) to be held in Ottawa this Fall — Call for Papers

The Canadian Society for International Health (CSIH) and the Canadian University Consortium for Health in Development are co-sponsoring Canada's first Conference on International Health with the support of the International Development Research Centre and the Pan American Health Organization. The theme for the conference is "Canada's Evolving Role in Health and Development — Where We've Been and Where We're Going".

The Conference will be held on Ottawa, November 13-15 and members of the international health community are invited to submit abstracts of research papers and symposia/workshop proposals. Papers and

symposia/workshop proposals from the broad field of international health and development including social, economic, preventive, clinical and biomedical issues will be accepted.

Abstracts of research papers can be presented via the traditional route of a ten-minute oral presentation with five minutes for discussion, as part of a panel, as a poster (discussion) presentation, or as a roundtable discussion. The deadline for submission of abstracts is **August 15, 1994**. Paper abstracts and presentation proposals may be submitted to CCIH 1994 Program Committee, 170 Laurier Ave. W., Suite 902, Ottawa, ON, K1P 5V5.



National Dental Hygiene Campaign 1994 October 16-23

REGISTRAR/ CHIEF ADMINISTRATIVE OFFICER COLLEGE OF DENTAL HYGIENISTS OF ONTARIO (CDHO)

The newly formed regulatory body of the profession of Dental Hygiene in the province of Ontario requires a Registrar/Chief Administrative Officer (CAO).

This Registrar/CAO will be responsible for:

- the day to day management of the organization
- acting as Secretary to Council and Committees
- dealing with governments, professional associations, educational institutions and related health groups.

Candidates should have strong leadership, administrative and interpersonal skills, knowledge of health legislation and regulations.

Bilingualism is an asset. Eligibility for registration as a Dental Hygienist in the province of Ontario is preferred.

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Only those applicants to be interviewed will be contacted.

Please submit your resume by 17 August, 1994 to:

College of Dental Hygienists of Ontario
69 Bloor Street East, Suite 300
Toronto, Ontario M4W 1A9

Teledyne Water Pik Expands Its Line of Oral Hygiene Products

Teledyne Water Pik Canada Ltd. has expanded its line of oral hygiene products with the announcement of the Water Pik Professional Dental System (model WP-32C). The new system complements the company's Perio Pik Subgingival Irrigation Handpiece and the Plaque Control 3000 Plaque Removal Instrument. Sales and marketing manager, Ralph Cain, says the new system meets the need for effective subgingival delivery of anti-microbial solutions.

In April, Teledyne Water Pik integrated all aspects of the businesses of two other dental suppliers, Getz and Hanau, into its operations. A third company, Teledyne Mecca, is also being integrated into the company. According to president and general manager Peter Leaney, these changes mean that the Getz and Hanau lines will be handled out of a Canadian-based operation for the first time and dental dealers will now be carrying a comprehensive array of professional dental products for the office, clinic and classroom. The Getz line includes consumable products used by dental hygienists for preventive and restorative dental procedures.

Health and Cultures — New Resources for Health Care Providers

The spring edition of Health Canada's quarterly publication *Health Promotion in Canada* announced the release of two new resources that may be of interest to dental hygienists who provide oral health care to clients from different ethnic groups. *Volumes I and II of Health and Cultures: Exploring the Relationships* focus on racially and culturally sensitive health care in Canada and examine key issues from vantage points of diverse disciplines, research perspectives and experiences.

Volume 1 (345 pages) is a collection of articles on health policy, professional practice and education while Volume II (347 pages) examines issues relating to programs and service development for pluralistic communities. An introduction by editors Ralph Masi, MD, CCFP and Professors Lynette Mensah and Keith A. McLeod outlines the historical development of multicultural care in Canada, as well as its concepts, principles and applications.

Copies of the English-only publication are available for \$18.95 each (plus \$2 shipping and handling) from Mosaic Press, 1252 Speers Road, Units 1 and 2, Oakville, ON L6L 5N9. Tel./Fax (416) 825-2130.

Clinical Study Confirms Value of New Oral Cancer Diagnostic Aid

OraScan manufacturer, Zila, Inc., reports that a significant clinical study using its product confirms that it is a valuable tool for dental professionals to use when diagnosing oral cancer. Newell Johnson, Nuffield Professor of Dental Sciences at the Royal College of Surgeons, Kings College School of Medicine and Dentistry, used the product to test 102 patients at risk in Sri Lanka and Pakistan, where oral cancer is the number one cause or cancer-related deaths. Patients were first given a routine visual examination; then the OraScan rinse sequence was used and a second examination was conducted to look for stained lesions. Johnson concluded that all 11 carcinomas

observed by the experts were successfully stained by OraScan and that the product also stained an additional 12 lesions that had been overlooked by the experts, five of which demonstrated microscopic dysplasia, a potentially pre-cancerous condition.

Although some experts maintain that visual examination and palpation are the only clinical procedures necessary prior to biopsy and that there is no scientific evidence to support the suggestion that the use of toluidine blue will lead to earlier diagnosis of oral cancer, others say it is a valuable adjunct to the practitioner's prepared mind, educated eyes and finger tips.

OraScan was introduced in Canada last summer and utilizes toluidine blue as a staining agent. It is sold only to health professionals and typically administered during a routine dental check-up. It is now approved for use in Australia and being reviewed by regulatory authorities in the United States and the United Kingdom.

Oral cancer is the 8th most common cancer type, but one of the deadliest — owing to a history of late detection. Five-year survival rates are 18% for late-stage detection, 51% overall and 75% for early-stage detection.



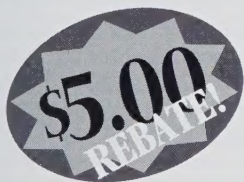
Canadian Public Health Association Announces New HIV/AIDS Resource for Caregivers

The Canadian Public Health Association (CPHA) has announced the availability of a new resource that provides important infection control information for non-professionals caring for persons living with HIV/AIDS in the community. The resource supports family members and other non-professionals as well as HIV positive people in understanding how HIV is transmitted

and how to minimize opportunities for infection.

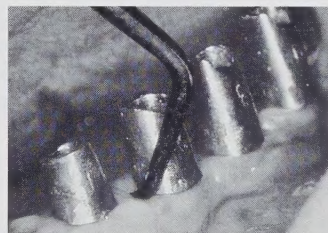
HIV/AIDS topics covered include the essentials of safe care, responsibilities of the caregiver to him or herself and to the person with HIV/AIDS, special precautions to observe with needles, and safety procedures for home activity areas such as the kitchen, bathroom/laundry and yard.

The booklet and a small poster are available at no charge from the National AIDS Clearinghouse, Canadian Public Health Association, Suite 400, 1565 Carling Avenue, Ottawa, Ontario, K1Z 8R1.



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Reviewed by:
Carol Barr Overholt, RDH

Radiography for Children and Adolescents

By: **Fred Ferguson, DDS,**
Stephen A. Festa, DDS
Publication: *Oral Health, October 1993*

In recent years, both members of the profession and dental clients have expressed concern regarding overuse of radiographs.

Although fast-speed films, lead aprons with thyroid collars, and improved technology have substantially reduced client exposure, concerns about the lifetime cumulative affect of radiographic exposure remain.

In 1990 a survey of paediatric and general dental practitioners conducted by McKnight and Hanes was published. The survey's questionnaire provided case history scenarios, and participants were asked to select radiographs based upon the cases. The results of the study indicated that dentists from both groups selected an unnecessary number of radiographs.

In 1977 the United States Department of Health and Human Services (U.S.D.H.H.S.), in conjunction with "several national dental societies", produced a publication entitled "Dental Radiographic Examinations". Its purpose was to guide practitioners in the selection of radiographs, basing choices upon client profiles:

1. Client visit types — new vs. recall client
2. Client category — child, adolescent, adult
3. Risk — presence/absence of caries, periodontal disease and eruptive stage

Other risk factors such as habits and past medical/dental history, which could increase the client's risk of oral disease, were also considered since these factors could necessitate a change in radiograph selection.

The guidelines assume an uneventful medical history and that extra-oral findings were within normal limits. Cases requiring a greater number of radiographs (i.e. orthodontic consultation or dentoalveolar trauma) were avoided, as the study wished to focus on problems common to general paediatric care.

Using the subheadings of the paper, the guidelines are as follows:

Primary Dentition (6 mos – 5 1/2 years):

The most common client presentations requiring radiographic exposure are caries and traumatic injuries.

If closed interproximal contacts are present, two size-zero films are recommended for initial bitewing (BW) radiographic exposure, by no later than 3 1/2 years of age. Subsequent BW

exposures, or selected periapicals (PAs), may be based upon both the frequency and extent of interproximal carious lesions or other risk factors. Maxillary anterior teeth may be exposed using a size-two film and using the occlusal technique, optimally at the time when the client is near the mixed dentition stage. Routine exposure of these teeth, in the absence of trauma, caries, or abnormal dentoalveolar development, is discouraged. The article acknowledges that there are practitioners who would not support this point of view. The need for additional radiographs during the regular recall appointment bears close examination and should be based upon a specific indication.

Early Transitional Dentition (5 1/2 – 9 years)

After consultation with parents to determine if any familial variabilities in eruptive chronology exist, a panoramic (PAN) radiograph to evaluate the developing permanent dentition is indicated for this age group. The suggested optimal time for exposure is when the first molars and mandibular incisors have erupted into occlusion. The authors' rationale is that this optimizes the view of the developing permanent dentition. The second permanent molars, succedaneous teeth and maxillary anterior teeth that are near eruption are easily viewed. The presence of a mesiodens, or congenitally missing teeth, can be diagnosed from a panoramic radiograph. If third molar crowns are developing, they may also be assessed on this film. However, the potential for distortion and client movement must be taken into consideration.

Again, two size-zero films are recommended for the diagnosis of interproximal caries during an initial exam. PAs or BW exposure for a recall client require a review of past carious activity or risk factors. The authors stress that all radiographs, and particularly panoramic films, be "critically evaluated for uncommon or rare occult pathology" and note that panoramic films lack the detail of full mouth periapicals (FMPAs)

Mid To Late Transitional Dentition (9 – 13 years):

Size two BW radiographs are recommended for this age group, since they allow a greater view of exfoliating and erupting teeth, and because clients will require fewer exposures than with the use of size-zero BWs. For new clients, a PAN or FMPAs can be prescribed for assessing the developing dentition. This article

discourages taking an additional PAN or FMPAs at this developmental stage if either was taken during the early transitional phase since little new information would be provided and significant findings limited.

Young Permanent Dentition (13 years to 3rd Molar Eruption, if present):

Upon the eruption of the permanent dentition, a PAN or FMPAs are only required when clinically demonstrated circumstances exist. Four individual PAs or a PAN may be considered if the presence of third molars could become problematic. Four size-two BWs may be used for caries inspection.

The assessment of the frequency for interproximal BW radiographic exposure is again based upon caries activity history. Although, as the client grows older, the exposure interval may decrease, the authors acknowledge that this age group may be at increased risk from certain behavioural factors. They cite poor oral care, dietary factors and lifestyle changes (i.e. living at college) as considerations when assessing the frequency of BW exposure.

Management Considerations

Child client management concerns may be detected during the assessment phase of dental treatment. It is essential that the clinician discuss with the parents or guardians what behaviour management techniques may be used to access a radiographic evaluation, and to obtain informed consent.

The authors state that "to provide treatment without necessary radiographs is unethical, unprofessional and malpractice", and that those very young clients with a traumatic injury/abscess, for example, may require restraint for exposure. The suggested methods are either a pedwrap, or the parent or clinician properly draped. Film holders may also be of benefit.

Special needs clients may require alternative radiographic treatment. One recommendation is the consideration of the use of extra-oral films. Mild sedation and physical support can also be considered. If radiographic compliance is not possible, the clinician must monitor factors that would alter the client's oral health, and closely observe their status.

With staff patience, and a step-by-step approach, success may be met.

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No significant changes in bacterial sensitivity, overgrowth of potentially opportunistic organisms or other adverse changes in the oral microbial flora were observed following the use of Peridex for six months. Three months after Peridex use was discontinued, the number of bacteria in plaque had returned to pre treatment levels and sensitivity of plaque bacteria to chlorhexidine gluconate remained unchanged.

Studies conducted with human subjects and animals demonstrate that any ingested chlorhexidine gluconate is poorly absorbed from the gastrointestinal tract. Excretion of chlorhexidine gluconate occurred primarily through the feces (approximately 90%). Less than 1% of the chlorhexidine gluconate ingested by these subjects was excreted in the urine.

INDICATIONS AND CLINICAL USE: Peridex is indicated for use as part of a professional program for the treatment of moderate to severe gingivitis, and for management of associated gingival bleeding and inflammation between dental visits. For patients having coexisting gingivitis and periodontitis, see PRECAUTIONS.

CONTRAINDICATIONS: Peridex should not be used by persons who are known to be hypersensitive to chlorhexidine gluconate or other formula ingredients.

WARNINGS:

USE IN PREGNANCY: Reproduction and fertility studies with chlorhexidine gluconate have been conducted. No evidence of impaired fertility was observed in male and female rats at doses up to 100 mg/kg/day, and no evidence of harm to the fetus was observed in rats and rabbits at doses up to 300 mg/kg/day and 40 mg/kg/day, respectively. These doses are approximately 100, 300, and 40 times that which would result from a person ingesting 30 ml (2 capfuls) of Peridex (0.12% chlorhexidine gluconate) per day. Since controlled studies in pregnant women have not been conducted, the benefits of use of the drug in pregnant women should be weighed against possible risk to the fetus.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. In parturition and lactation studies with rats, no evidence of impaired parturition or of toxic effects to suckling pups was observed when chlorhexidine gluconate was administered to dams at doses that were over 100 times greater than the dose which would result if a person ingested the entire recommended dose of Peridex (0.12% chlorhexidine gluconate) on a daily basis.

USE IN CHILDREN: Since the safety and efficacy of Peridex in children has not yet been fully established, the benefits of its use should be weighed against the possible risks.

PRECAUTIONS:

1. For patients having coexisting gingivitis and periodontitis, the absence of gingival inflammation following treatment with Peridex may not be indicative of the absence of underlying periodontitis. Appropriate treatment of periodontitis is therefore indicated.

2. Peridex may cause staining of oral surfaces such as the film on tooth surfaces, restorations, and the dorsum of the tongue. Stain will be more pronounced in patients who have heavier accumulations of unremoved plaque.

Stain resulting from use of Peridex does not adversely affect the health of gingivae or other oral tissue. Stain can be removed from most tooth surfaces by conventional professional prophylactic techniques. Additional time may be required to complete the prophylaxis.

Discretion should be used when treating patients with exposed root surfaces or anterior facial restorations with rough surfaces or margins. If natural stains cannot be removed from these surfaces by a dental prophylaxis, patients should be excluded from Peridex treatment if the risk of permanent discoloration is unacceptable. Stains in these areas may be difficult to remove by dental prophylaxis and on rare occasions may necessitate replacement of these restorations.

3. A few patients may experience a slight and temporary alteration in taste perception while undergoing treatment with Peridex. Most of these patients accommodate to this effect with continued use of Peridex.

4. For maximum effectiveness the patient should avoid rinsing their mouth, eating or drinking for about 30 minutes after using Peridex.

ADVERSE REACTIONS: No serious systemic reactions associated with use of Peridex were observed in clinical testing. However, some adverse reactions have been reported in studies with Peridex or other chlorhexidine-containing mouth rinses. The most common side effects associated with chlorhexidine gluconate oral rinses are (1) an increase in staining of oral surfaces, (2) an increase in supra gingival calculus and (3) a slight and temporary alteration in taste perception. (see PRECAUTIONS). Epithelial irritation and superficial desquamation of the oral mucosa have been noted in studies of children using 0.12% chlorhexidine gluconate which were reversible upon discontinuation. There have been rare cases of parotid gland swelling and inflammation of the salivary glands, in patients using Peridex.

SYMPTOMS AND TREATMENT OF OVERDOSAGE: Ingestion of 30 or 60 ml of Peridex (0.12% chlorhexidine gluconate) by a small child (10 kg or less body weight) might result in gastric distress, including nausea, or signs of alcohol intoxication. Medical attention should be sought if more than 120 ml of Peridex is ingested by a small child or if signs of alcohol intoxication develop.

DOSAGE AND ADMINISTRATION: Peridex therapy should be initiated directly following a dental prophylaxis. Patients using Peridex should be reevaluated and given a thorough prophylaxis at intervals no longer than six months; they should be referred for periodontal consultation as necessary.

Recommended use is twice daily oral rinsing for 30 seconds, morning and evening after tooth brushing. Usual dosage is 15 mL (marked in cap) of undiluted Peridex. Peridex is not intended for ingestion and should be expectorated after rinsing. Rinsing the mouth, eating or drinking should be avoided for about 30 minutes after using Peridex.

The suggested initial course of therapy is 3 months, at which time patients should be recalled for evaluation. At the time of the recall visit, the dental professional should:

- Evaluate progress, remove any stain, and reinforce proper home care techniques.

- If gingival inflammation and bleeding is controlled, discontinue Peridex therapy and recall the patient in three months to assess gingival health.

- If gingival inflammation and bleeding persists, continue Peridex therapy for an additional 3 months and schedule a three-month recall for evaluation.

- Evaluate for evidence of epithelial irritation, desquamation and parotitis.

The following generally accepted grading scheme may be of use in evaluating the severity of gingivitis.

Loe and Silness
GINGIVAL INDEX (GI)

Grade	Description
1	Normal gingiva, no inflammation, no discoloration, no bleeding.
2	Mild inflammation, slight color change, mild alteration of gingival surface. No bleeding.
3	Moderate inflammation, erythema, swelling, bleeding on probing or when pressure applied.
4	Severe inflammation, severe erythema and swelling, tendency toward spontaneous hemorrhage, some ulceration.

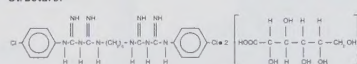
An occasional missed dose can be ignored if the patient is generally compliant with the prescribed regimen.

PHARMACEUTICAL INFORMATION DRUG SUBSTANCE

Proper Name: Chlorhexidine gluconate (U.S.A.N.)

Chemical Name: 1,1'-hexamethylene bis[5- (p-chlorophenyl) biguanide] di-D-gluconate

Structure:



Molecular Weight: 897.8

Description:

Chlorhexidine has basic character and exists in the di-cationic form at physiologic pH. The two protonic positive charges become somewhat localized on the bi-guanide portion of the molecule. Both pKa's are reported as 10.78 ± 0.06. The gluconate salt is soluble in excess of 70% (w/v) in water at 20°C.

At 19–21% w/v chlorhexidine gluconate solution is colourless to pale straw-coloured and is odourless to almost odourless (British Pharmacopoeia).

COMPOSITION: Peridex contains 0.12% chlorhexidine gluconate in a base containing water, alcohol, glycerin, PEG-40 sorbitan di-isostearate, flavour, saccharin sodium and FD&C Blue #1 Dye.

STABILITY AND STORAGE: Store above freezing (0°C).

INCOMPATIBILITIES: None known.

SPECIAL INSTRUCTIONS: None.

AVAILABILITY OF DOSAGE FORM: Peridex oral rinse (0.12% chlorhexidine gluconate) is supplied as a blue liquid in 475 mL amber plastic bottles with child-resistant dispensing closures.

Store above freezing (0°C).

REFERENCE

1. Grossman E., Reiter G., Sturzenberger OP, et al. Six-month study of the effects of a chlorhexidine mouthrinse on gingivitis in adults. *Journal of Periodontal Research*. 1986;21(suppl 16):33-43.

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The Importance of Communication to Dental Hygiene Practitioners: Skills in Empathy and Understanding of the Client

By:
J.F. Pimlott, MSc
G.C. Hess, PhD

In recent years the problem of client adherence to health care recommendations has gained a significant amount of attention. This interest reflects a recognition that regardless of their potential benefit to the client, both preventive and treatment recommendations are of little value unless the client implements and maintains them. Too often dental hygienists give a similar speech on the importance of daily flossing to all of their clients. In order to increase client compliance, dental hygienists need to restructure their information according to the needs of the individual clients. It is recognized by many behavioral scientists that client compliance is enhanced by the use of a client-centered approach to communication rather than the traditional problem centered methods.^{1,2}

At the University of Alberta students in the two year dental hygiene program are required to take a course in communication. The goal of the course is to teach students how to communicate effectively with their clients in such a way that encourages client compliance of healthy personal dental care. In order to evaluate whether or not students were learning the needed skills, an inventory was created to evaluate their skills as they began and as they finished the course. Unlike most university courses where an instructor can assume students have little knowledge of the course content upon entry, the communications course includes many skills that some students may have in their repertoire of social interaction skills. Therefore, it seemed important to use a pre and post test format to see if students improved their skills during the course. The inventory, called the Communication Skills Inventory (CSI), was created by incorporating research and theory from the field of educational psychology. It is modeled after the work of Gazda³ and Carkuff⁴ but has been extensively adapted to the context of dental hygiene.

The purpose of the current paper is therefore twofold. First, the philosophy and theory of client-based communication is explained, emphasizing those aspects of communication most important for dental hygiene practitioners. And second, the organization and rationale of



J.F. PIMLOTT, MSc

the Communication Skills Inventory (CSI) is discussed. It is the authors' hope that other dental hygiene educators will wish to use this inventory with their students. Sample questions are included in this paper, but educators desiring the entire inventory can obtain it from the authors.

The Philosophy of Client-Centered Practice

Historical perspectives of communication

It is generally acknowledged that the humanists began to influence trends in psychology in North America during the hippie era of the 1960s. The leaders in the movement reacted both to the philosophically-based emphasis on the id, ego, and superego of psychoanalysis and to the rigid, experimental emphasis on the stimulus and response of behaviourism. The humanists were sometimes called the "third force of psychology": Freud's⁶ psychoanalytic theory, being the first force; and Pavlov's⁷, Watson's⁸ and Skinner's⁹ behaviourism, being the second force. Abraham Maslow (1971)¹⁰, with his philosophical and theoretical writing is usually considered to be the father of humanism; Carl Rogers (1961)¹¹ was extremely influential in the field of education. Both Maslow and Rogers imagined that humanistic psychology could help people become more in touch with themselves and those around them by talking about their concerns and issues. Neither envisioned a need for an omnipotent psychotherapist who could delve into a client's unconscious mind like Freud believed. They also did not believe that controlling a person's behaviour by setting up strong stimulus-response contingencies captured the essence of a person. They emphasized people's human qualities: their uniqueness, their awareness of themselves and others, their freedom and responsibility, their values and beliefs, and, most importantly, their potential to achieve and accomplish their life goals. Communication was seen as the key to tapping one's potential in the drive towards self-actualization. It became a central concept as humanistic beliefs were adapted from psychology to counselling, education and the health fields.

In the years since the 60s, there have been many changes in both the beliefs of the humanists and in the general popularity of those beliefs.¹² As the pendulum swung away from traditional psychology and education, many educators and writers¹³ believe it swung too far. The free thinking of the post war era has since tightened up in the days of recession and world conflict. However, the health care field owes a great deal to the early humanists, even though today most of the concepts have been reinterpreted in light of current thinking. The contributions of the humanists to dentistry include their emphasis on communication, on considering client needs, on the relationship between the dental professional and the client, and on health education and prevention. There has been a significant shift from a time when members of the health care profession were viewed as all-knowing and had to maintain an authoritarian, hierarchical position towards the client. Currently in a client-centered approach, clients are encouraged to be knowledgeable and responsible for their own health care. The focus on communication as an essential skill for health care professionals has been widely supported in the recent literature.^{14,15,16,17,18}

What does client-centered oral health care mean?

Client-centered dentistry has roots in Rogers'¹¹ client-centered therapy. He stressed that a psychotherapist must have empathy and unconditional positive regard for a client and be genuine (honest) in order to be able to communicate with the client. The client must also perceive that the therapist has these three qualities in order to bring about a personality change in the client. This central belief of Rogers emphasizes the role of the professional as the helper within the interaction.

However, Rogers was writing about psychotherapists and was taking the interaction beyond that of simple communication into the domain of counselling and psychotherapy, where the helper hopes to facilitate a personality change within the client. Communication skills are seen by Rogers and other educational psychologists^{19,20} as being the first steps within the counselling process.

In order to be relevant to the oral health practitioner of the 1990s, Rogers' core beliefs have to be reinterpreted or reframed. The authors believe that Rogers' core conditions of empathy, genuineness, and positive regard are still important to effect change in the client. However, oral health practitioners are looking for healthy change in oral health care, not personality change. Therefore, a better way of expressing the core beliefs as they relate to oral health education may be as follows: that if oral health professionals show empathy, positive regard, and genuineness in their relationships with their clients, then these professionals will be better able to openly and honestly communicate with their clients in such a way that promotes responsible oral health care on the part of the client. In other words, the oral health professional has to understand and communicate with the client so that she/he is able to adapt a typical health care program to the needs and wants of a particular client.

The Goal of the Client-Practitioner Interaction

Within the model of client-centered oral health care, the initial focus of the practitioner is totally upon the client. Once a relationship is established and the practitioner understands the client and the client perceives that he/she is understood, only then does a two-way interaction about treatment concerns begin. The goal of the entire interaction with the client is to understand the client's feelings, to understand the client's thoughts, and to understand the client's internal frame of reference thus enabling the oral health practitioner to use her/his dental skills, to teach the client in a way that will ensure the client will listen,

and to offer the best possible oral health care. The client is seen as ultimately assuming the responsibility for continuing oral health care, so the client must understand the importance of the treatment and be motivated to continue it.

“An oral health practitioner who communicates effectively has empathy for that client and shows it.”

Empathy

Of all the variables in health communication, empathy is regarded as the most essential and at the same time one of the most complex variables operating in the communication process.²¹ Empathy has cognitive, affective, and communication components. The cognitive perceptual process involves observing a client's behaviour and processing the obtained information. The affective process involves being sensitive to a client's feelings. Both aspects need to be considered if effective communication is to be achieved.

Empathy is the ability to develop a full understanding of another person's condition and feelings and relate that understanding to the person. It means seeing the situation as if through the other's eyes. It means comprehending from the other person's point of view. It means understanding possible fears of pain, or treatment cost, or possible embarrassment, or any other feeling along a whole continuum of positive and negative emotions. The practitioner understands and acts accordingly. Sometimes the dental hygienist might discuss the fears directly. Another time, sensing that talking about a fear might add further embarrassment at that particular point in time, the dental hygienist might skirt the issue for awhile and come back to it later when the dental hygienist believes the client will be better able to cope. Having empathy, and showing it, takes time. However, in the long run, the authors believe that conveying empathy significantly improves the level of oral health care.

Specific communication skills

An oral health practitioner who communicates effectively has empathy for that client and shows it. In addition she/he has many specific skills of communication which are used to develop and maintain the relationship with the client, to teach oral health care, and to respond to the client's oral health needs. We believe strongly that dental hygienists cannot use the same skills in the same order with every client. One has to focus on the client and adapt the skills accordingly. One has to use them thoughtfully, with full awareness of the probable consequences of using each.

The skills needed most often in the practice of a health professional are those which involve being approachable, using and observing non-verbal communication, basic verbal skills of understanding, and, less frequently, the focusing and responding skills. The final skills introduced were conflict resolution skills and the process directions of crisis intervention. The skill of listening is an aspect that is incorporated into all of the skills listed.

Figure 1 presents the specific skills taught in the communications course, a list which has been adapted from the work of Ivey and Gluckstern.^{19,20}

Figure 1.



The Communication Skills Inventory — CSI

The Communication Skills Inventory (CSI), was designed to evaluate generic communication skills (non-theoretical, non-specific practical skills without technical jargon or specific vocabulary). The CSI contains 19 items: 10 multiple choice items which measure empathic listening skills, 7 multiple choice items which measure empathic responding skills, and 2 open-ended items which measure problem-solving skills. The CSI was designed to be used to 1) evaluate the communication training program; 2) to substantiate necessary changes to the program; and 3) to evaluate changes in students' levels of communication skills and empathic listening skills. The inventory has three parts.

The Communication Skills Inventory was developed over a fifteen year period while working with undergraduate university students in dental hygiene, dentistry, pharmacy, and education. After each set of papers were completed the authors studied the item analysis (usually a LERTAP analysis) and edited questions and distracters accordingly. In some cases, students worked in small seminar groups with an instructor as part of the communications course. In these cases, the instructor first rank ordered the students on their communication skills displayed in the seminar during role play situations. Their clinical rankings were then compared with student scores on the inventory. Generally, a very high correlation between the individual's clinical rating and inventory scores was found. In cases where the CSI score did not fit with the clinical ratings, students were interviewed to gain their feedback on the inventory. Over time, the students and instructors have both begun to trust the test scores. Space does not permit inclusion in this article of the many analyses which have been run to look at the internal and external validity of the scale. The three parts of the inventory are explained in detail below.

Part I — Listening Skills

The first part is designed to assess students' listening skills, often considered the most fundamental skills of good communication.²² Specifically students' ability to detect the underlying emotion or message of a speaker's words is measured using ten multiple-choice questions from the Jones Mohr Listening Test.²³ Brief spoken statements are presented by means of an audio taped recording, and subjects are required to circle the multiple choice alternative that best corresponds to the speaker's intended meaning. All answers to this part of the inventory are keyed to a single correct response. Some sample items are shown below.

Communication Skills Inventory

Part I — Listening Test

An audio-tape will be played to accompany the following questions. Circle the letter beside the response that best corresponds to the speaker's intended meaning.

- | | |
|--|--|
| 1. Let's go see him again.
a) I just can't wait.
b) I'd like to get something from him.
c) I never want to see him again.
d) I really enjoy seeing him. | 2. Ah, I just can't seem to get involved.
a) I wish I were different.
b) I don't want to get involved.
c) ...but I want to get involved.
d) I'm really kind of bored. |
| 3. Gee! It's good to see you again.
a) I really don't enjoy this.
b) I'm happy to see you.
c) I like you.
d) It's about time.... | 4. It's nice to be together again.
a) I've missed you so much.
b) It makes me feel at peace.
c) ...but I liked it better without you.
d) I'm glad you're home. |

Part II — Specific Communication Skills

The second part of the inventory, also made up of multiple choice items, was adapted from Carkhuff's (1980) and Gazda's (Gazda, Asbury, Balzer & Childers, 1984) empathy and communication training scales. In response to a hypothetical statement made by a client, students identified the answer which best facilitated communication. Each of the four alternatives represent a different level of global communication. The "best" response is one categorized as a level 3 or 4 response, according to Gazda. Such responses facilitate the relationship between the dental hygienist and the client and show that the dental hygienist has earned the right to help and directly aid in problem-solving of the situation at hand. For each question a "best" and "next best" response was keyed so that educators had some flexibility in the scoring of the items in this section. Two distracters were clearly seen as being harmful to the communicative interaction.

Communication Skills Inventory

Part II — Discrimination of Helper Responses

For each of the following introductory statements, indicate the letter of the response which would best facilitate communication. You do not know anything about the people except the words that are printed here. Make only one response per item.

Client to Dental Hygienist: "Well...ah, ah,...I would like to have the new bridge the dentist described but, ...ah, well maybe I'll just go home and think about it for awhile and...ah, call your office in awhile."

- a. "Are you sure you don't have any questions about the procedure or the cost?"
- b. "You seem hesitant to get the bridge yet you say it's what you want."
- c. "You're not going to let someone talk you out of it, are you?"
- d. "I find that when clients put off making the decision for too long that the problem usually gets worse."
- e. "You sound like you're not quite sure but you are going to think about it."

Dental Client to Dentist or Dental Hygienist: "It seems like everybody has plans for my appearance; my parents, my spouse, my friends, everybody — but I don't know what to do. I don't know whether to spend all the time and money to have new caps put on or not."

- a. "Well, I think it is important that you make the decision. Don't listen to the others. You are the one who has to spend the time and money and live with the results."
- b. "Perhaps you could try standing up for yourself and asserting your own wishes."
- c. "I know how you feel, I have thirty people who all want different things from me. Frustrating, isn't it?"
- d. "You resent having other people make plans for you, and yet you are feeling lost about your own directions."
- e. "Uh...so what do you think you should do?"

Part III — Open-ended Responses, Showing Empathy

Gazda's scale was also used in the construction and evaluation of the open ended questions in the third part of the inventory. Each of the situations described in the two open-ended questions are phrased in a way which would allow students to feasibly offer any level of response. Again the instructions ask for a response "that best facilitates communication." These questions are scored on a scale of 0 to 2, indicating how well the responses reflect the 1) content and 2) feelings of the person speaking in the hypothetical situation, and also, how much 3) empathy was demonstrated in the response to that person. The best possible score is, therefore, a 6 on each of the two questions. Two sample questions are shown in the box below.

Communication Skills Inventory

Part III — Open Responses

In this part of the inventory you are to write your own response to statements rather than choosing a response from the multiple-choice format. In response to each of the statements given write a response which best facilitates communication. Write on the answer sheet provided.

1. **Dentistry/Dental Hygiene Student to Professor:** "I don't know why I have to take all these science and research courses. I'm never going to do any research. I just want to graduate, so that I can work in private practice."
2. **Client to Dental Hygienist or Dentist:** "I went to another dentist down the road and he didn't do the right thing to make my tooth better. How do I know you are going to do the right thing to make my tooth not hurt any more?"

The Communication Skills Inventory, in its current form, seems to offer one objective measure of communication skills which can aid dental hygiene educators in assessing the skills of their students. The authors welcome the use of the inventory by other educators in the field. Through collaboration further refinements of the inventory are possible.

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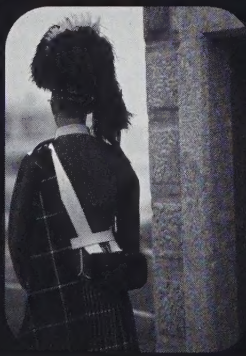
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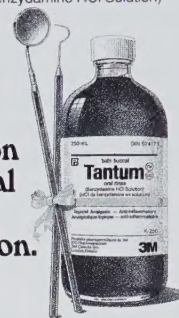
This paper was written by two authors who have integrated their knowledge of two disciplines, dental hygiene and educational psychology. One author, Jan Pimlott, is Associate Professor in the Faculty of Dentistry and Director of the Division of Dental Hygiene and the other, Gretchen Hess, is an Associate Professor in the Department of Educational Psychology and Assistant Dean in the Faculty of Education. They strongly believe that excellence in communication skill training among practitioners in dental hygiene is dependent upon the integration of their two fields. Together they have researched the area and taught the communications skills course within the Dental Hygiene program at the University of Alberta.

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"Tantum" Oral Rinse is indicated for relief of pain in acute sore throat and for the symptomatic relief of oro-pharyngeal mucositis caused by radiation therapy.

Contraindications

"Tantum" Oral Rinse is contraindicated in subjects with a history of hypersensitivity to any of its components.

Precautions

The use of undiluted "Tantum" Oral Rinse may produce local irritation manifested by burning sensation in patients with mucosal defects. If necessary, it may be diluted (1:1) with lukewarm water. Since "Tantum" Oral Rinse is absorbed from the oral mucosa and excreted mostly unchanged in the urine, a possibility of its systemic action has to be considered in patients with renal impairment.

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Do the Eating Habits of Anorexics and Bulimics have an Effect on their Oral Health?

The following paper was submitted by Michele Ediger, a dental hygiene student at the University of Manitoba.

Introduction

Anorexia nervosa is a psychosomatic eating disorder characterized by self-imposed starvation, intense fear of becoming fat, and distorted perception of body image. Anorexics tend to maintain their body weight about 15% below normal levels. Bulimia nervosa, a related but distinct eating disorder, is also characterized by an intense fear of becoming fat. This disorder differs from anorexia in that bulimics maintain appropriate body weights. Bulimics typically demonstrate recurrent episodes of binge-eating and then engage in various methods to prevent weight gain, such as self-induced vomiting, strict fasting, rigorous exercise, or inappropriate use of diuretics or laxatives.

Because both eating disorders are associated with maladaptive eating patterns, one would expect that the oral health of anorexics and bulimics would be compromised. Indeed, many case studies investigating the oral health of anorexics and bulimics report that these individuals demonstrate severe oral pathosis. Despite these reports, several empirical studies suggest that anorexics and bulimics do not differ from the general population with regard to their oral health. This paper will discuss recent research findings regarding the oral health of anorexics and bulimics by comparing the results of case studies to those empirical investigations in three areas: enamel erosion, gingival status, and incidence of decay.

Enamel Erosion

Enamel erosion is often reported in case studies as the most likely dental pathosis among anorexics and bulimics (1-4). Clinically, this erosion may present as a raised appearance of the incisal edges of

maxillary anterior teeth, and/or an anterior open bite. According to Altshuler (1), enamel erosion may occur in bulimics and anorexics as a result of frequent regurgitation. This author suggests that as the anorexic or bulimic vomits, the hydrochloric acid contained in vomitus breaks down the enamel and dentine of the teeth as it passes through the oral cavity.

A recent study by Miloslevic and Slade (5) indicates that although anorexics and bulimics may demonstrate enamel erosion, this dental pathosis may only be evident in those individuals who demonstrate frequent regurgitation. In that study, the dental status of bulimics who vomited, bulimics who did not vomit, and anorexics was compared to that of age-matched control subjects. Vomiting episodes were estimated among the eating disorder sample as the product of frequency of vomiting and the duration of each vomiting incident. The results indicated that a significant relationship existed between vomiting episodes and abnormally high erosion but only when the frequency of vomiting was greater than 1100 episodes.

Gingival Bleeding

Another oral pathosis reported in case studies as being characteristic of anorexics and bulimics is gingival bleeding. According to Harrison, George, and Cheatham (2), anorexics and bulimics may demonstrate gingival inflammation as a result of their limited diets. This author suggests that anorexics and bulimics may not ingest adequate amounts of ascorbic and folic acid. A lack of ascorbic acid may result in a more permeable oral epithelium. Which, in turn, may result in increased susceptibility to bleeding of the gingival tissues.

In a blind study, Miloslevic and Slade (5) examined gingival status in their comparison of anorexics, bulimics, and normal controls. The intra-oral soft tissues of the subjects were carefully examined and plaque deposits and gingival inflammation were scored using the



Plaque Index and Gingival Index respectively. Factors such as oral hygiene habits, type of toothbrush and toothpaste used, frequency of brushing and flossing, and brushing technique were analyzed. The results indicated that the mean plaque index scores and mean gingival index scores did not differ significantly between subjects with eating disorders and controls. These results suggest that although individuals with anorexia and bulimia may exhibit gingival inflammation, this inflammation is not likely to be greater than that seen in the normal population.

Caries

A third index of oral health discussed in case studies of anorexia and bulimia is incidence of caries. According to several authors (1, 3), anorexics and bulimics have a high incidence of caries as a result of high carbohydrate intake. Although anorexics ingest a lower than normal amount of food, the proportion of carbohydrates to protein and fats in their diet is high compared to the normal population. Bulimics on the other hand ingest a normal amount of protein and fats in their diet

Similar results were reported by Miloslevic and Slade (5). In that study the restorative status of anorexics, bulimics, and control subjects were charted and right and left bitewing radiographs were taken. Further DMFT scores were determined for each subject and a Dentobuff Kit was used for assessing the buffering capacity of subjects' saliva. Analysis of the data indicated no significant difference in the buffering capacity of saliva or DMFT scores between anorexics, bulimics, and the control subjects. Together, these studies indicate that anorexics and bulimics demonstrate no more caries or factors involved in caries development compared to the control population.

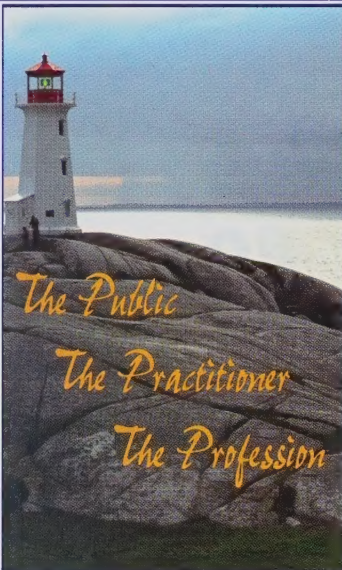
The empirical studies reviewed in this paper generally used larger samples of anorexics and bulimics, included control groups and utilized more in-depth assessments of dental health. These studies generally concluded that anorexics and bulimics do not differ significantly from the normal population in terms of gingival status and frequency of decay. The only oral pathosis that may be visible in individuals with anorexia and bulimia is enhanced dental erosion. This is only likely to be visible however in those individuals who demonstrate frequent episodes of vomiting.

1. Altshuler, B.D Eating Disorder Patients: Recognition and Intervention. *Journal of Dental Hygiene* 64:119-124, 1990.
2. Harrison, J.L., George, L.A., and Cheatham, J.L. Therapies for a Reduction of Dental Destruction Resulting From the Manifestations of Bulimia Nervosa. *Texas Dental Journal* 101:12-15, 1984.

3. Montgomery, M.T., Ritvo, J., Ritvo, J., and Weiner, K. Eating Disorders: Phenomenology, Identification, and Dental Intervention. *General Dentistry* 36:435-438, 1988.
4. Roberts, M.W., and Li, S. Oral Findings in Anorexia Nervosa and Bulimia Nervosa: A Study of 47 Cases. *JADA* 115:407-410, 1987.
5. Miloslevic, A., and Slade, P. D. The Oro-dental Status of Anorexics and Bulimics. *British Dental Journal* 167:66-70, 1989.
6. Liew, V.P., Frisken, K.W., Touyz, S.W., Beumont, P.J.V., and Williams, H. Clinical and Microbiological Investigations of Anorexia Nervosa. *Australian Dental Journal* 36(6):435-441, 1991.

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Completed papers must be submitted by April 10, 1995 for potential publication in Probe, CDHA's scientific journal.

For additional information contact: CDHA Central Office, 201-1018 Merivale Rd., Ottawa, ON, K1Z 6A5

Authors should submit one copy of Appendix A by February 15, 1995.

Appendix A for Abstract

CDHA's 6th Professional Conference

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June 16-18, 1995

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Additional Authors (Names Only)

It is expected that first authors will present the papers unless otherwise specified.

Choice of Presentation Format

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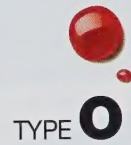
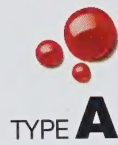
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_____ Table clinic

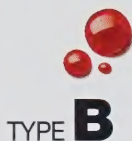
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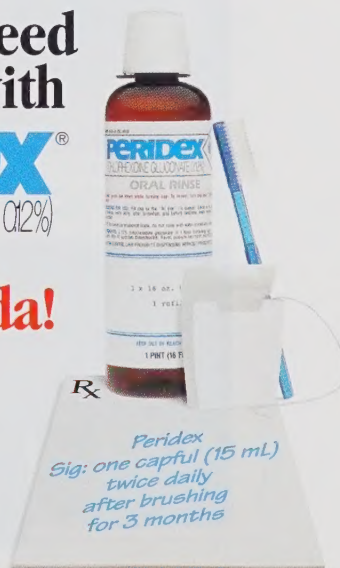
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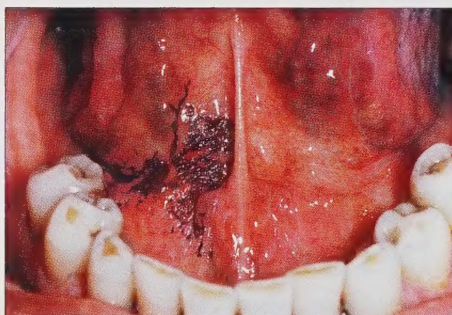




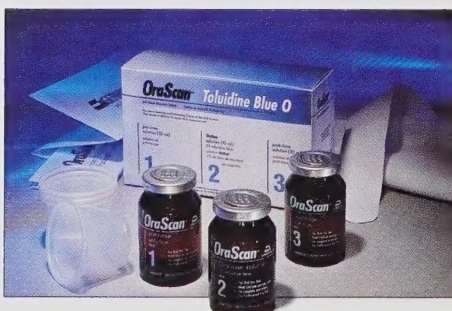
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* Mashberg, A, Samit: Early Detection, Diagnosis and Management of Oral and Oropharyngeal Cancer.

Ca-A Cancer Journal for Clinicals 39(27):67, 1989.

National Cancer Institute of Canada "Canadian Cancer Statistics," April 1992.

Chen J, Katz RV, Krutchkoff DJ. Epidemiology of Oral Cancer in Connecticut: J Dent Res 1989;68:910.

Silverman, S., Oral Cancer. 3rd ed., American Cancer Society, New York, 1990. pp 1,41.

Advertisement

BOOK REVIEW

Dental Ethics

Bruce D. Weinstein;

Lea and Febiger;

200 Chester Field Parkway,

Malvern, Pennsylvania, U.S.A. 19355-9725;

1993; indexed, 243 pages.

Reviewed by: Brenda Leggett, Dip.D.H., B.A.,

Professor, Dental Programs,

Algonquin College, Nepean, ON

In recent years there has been an increasing demand for resource material about professional ethics. The text, *Dental Ethics*, presents an important contribution to this need. Dr. Weinstein offers a chapter on ethical decision-making and has acted as editor for the remaining sections of the text. Accordingly, each chapter in this book represents collaboration between an ethicist expert and an expert in clinical Dentistry or Dental Hygiene.

The text is divided into three sections. The first section provides an introduction to the field of dental ethics. Here the reader is familiarized with the normative principles underlying ethical theory and presented with a framework for solving ethical dilemmas. Each chapter in this section includes a realistic case scenario which illustrates a moral conflict and identifies the steps taken to resolve the matter in an ethical fashion. This

format allows the reader to identify relevant values and facts. It also provides an opportunity for readers to analyze professional roles and responsibilities in relation to the dilemma presented. As the authors guide us through the steps of an ethical decision-making model, the question, "What *should* be done, and why?" is resolved.

Section two examines topical issues in Dental Practice. The analysis of professional relationships includes a chapter on Dentist – Dental Hygienist interactions. The author also explores the question of accountability, both to the dental team and to the patient. The sensitive topic of whistle blowing, as a professional obligation is also addressed, ie. What action is morally correct when professional self-regulation comes in conflict with the public interest? Discussions about treating HIV-infected clients, and the subject of informed consent to treatment, address both the legal and ethical aspects of these issues.

Of particular relevance to the emerging profession of Dental Hygiene are the guidelines for clinical research, presented in chapter eleven. The authors highlight the potential for ethical conflicts to arise when planning and conducting dental research and describe approaches to avoid these problems.

The final section of this text presents two extensive case commentaries which serve to further illustrate the process of ethical

decision-making. The first scenario focuses on aesthetic dentistry and considers the issues of informed consent and appropriate treatment. The final case involves the dilemma of a Dental Hygienist who, on moral grounds, hesitates to perform a procedure ordered by her employer. The authors suggest that these analyses might be used as models for exploring other professional issues.

This text is well-organized, moving logically from the presentation of underlying moral values and ethical principles, to the complex process of solving challenging ethical conflicts. The use of case studies and discussion questions in each chapter facilitate this objective. The table of contents is sufficiently detailed and provides a clear outline of the material within. An up-to-date PEDNET bibliography is included in appendix two.

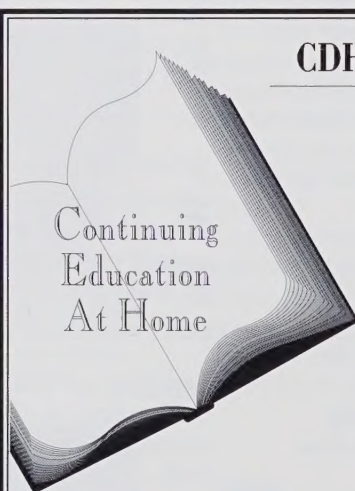
One major limitation of this book is its basis in American law and professional codes. In particular, the sections relating to the dental hygienist fail to reflect the current move towards self-regulation taking place in Canada. In spite of this shortcoming, this text appears to fulfill the authors' purpose: to help practising Dentists and Dental Hygienists resolve ethical problems. Both educators and students of Dental Hygiene will also find this text an excellent resource.

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CDHA's Book of the Month Suggestions

July:

***Spending Smarter and Spending Less
Policies and Partnerships for
Health Care in Canada***

Ralph Sutherland, M.D. and

Jane Fulton, Ph.D.

Canadian Hospital Association Press, 1994

ISBN #0-9693537-1-5 (bound)

0-9693537-2-3 (soft cover)

August:

Strong Medicine

How To Save Canada's Health Care System

Michael Rachlis, M.D. and Carol Kushner

HarperCollins, 1994

ISBN #000-255-281-7

News From Schools

News from the Schools is an annual feature published in the July/August issue of Probe. It is designed to provide educators with an opportunity to share their successes and new ideas, while giving CDHA members an opportunity to learn where some of their colleagues are and how dental hygiene programs are changing to meet the challenges the profession will face in the future. This year, of 23 dental hygiene programs invited to submit a report, six did not respond: Cambrian College, Sudbury, ON, Canadore College, North Bay, ON, the University of Toronto's School of Dental Hygiene, La Cite, Ottawa, ON, Niagara College, Welland, ON and Georgian College, Orillia, ON.



Dalhousie University School of Dental Hygiene Halifax, NS

The School of Dental Hygiene at Dalhousie University, which has a student body of 80 students, provides dental hygiene education primarily for the four Atlantic provinces. Candidates require one year of university prerequisites to be eligible for the two-year program. According to the School's Director, Joanne Clovis, students range in age from 19-45 years. She reports that there were three male students in the 93/94 program and student profiles show candidates have diverse social, economical and/or cultural backgrounds.

The faculty of the School consists of the Director, four full-time and 20 part-time members. The part-time faculty are involved in both clinical and didactic courses. This year faculty prepared for and completed the

accreditation site visit, and although the final report had not yet been received at the time this went to press, Clovis says preliminary information suggests the School will be granted accreditation.

One part-time and one full-time faculty member presented poster presentations at the American Association of Dental Schools meeting held in Seattle.

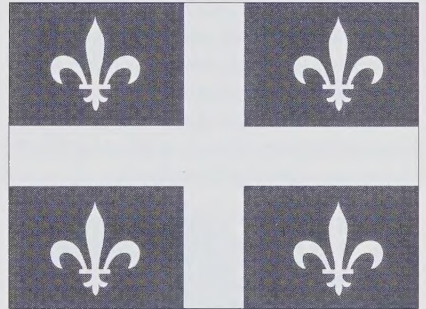
The school's clinical program is competency-based and requires students to present cases to their classmates. As the School is included within the Faculty of Dentistry, its students are able to experience integration in some courses as well as on the clinic floor. All students gain paediatric experience at a satellite clinic operated in association with an elementary school. In addition, students participate in an externship at Mount Saint Vincent Health Care Centre, a centre and residence for retired nuns. The students see patients in both the two-chair clinic and residents' rooms.

Ten students participated in an extra-mural practice experience in Newfoundland at the Grenfell Mission in St. Anthony this year. The two-week experience provided students with opportunities to deliver treatment in the hospital's dental clinic and learn a little about life "on the rock".

Dalhousie's Dental Hygiene students are required to present a table clinic as part of a major annual faculty event that also includes presentations by third year dental students. Clovis reports that this year two first prizes were awarded for table clinics entitled: Methods of Oral Hygiene Instruction for the Blind and Visually Impaired and Prenatal Counselling for Risk Groups for Nursing Caries.

As well the school's senior students participated in an exercise involving exceptional care patients. Students were required to either contribute to a support group, attend an association meeting or interview someone with exceptional needs. The exercise was intended to expand the students' experiences with exceptional care patients and appears to have met this goal.

The program's senior students graduated in May, while its first year students completed their year at the end of May. Clovis says that faculty breathed a sigh of relief as another academic year came to an end. She says they'll be busy over the summer updating, reviewing and revising their course offerings and continuing their research.



John Abbott College Ste Anne de Bellevue, QC

The Director of John Abbott College's Dental Hygiene Program, Jocelyne Long, reports that the college's 1993/94 academic year had an unusually high enrollment. The college accepted 37 first-year dental hygiene students although the program has a quota of 32. Long speculates that the high retention rate is, in part, indicative of difficult times on the job market since most of the 42 applicants originally accepted actually registered. In May, the College graduated 29 dental hygiene students, its largest class ever.

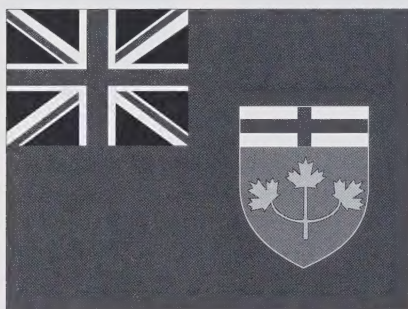
Long reports no new developments on the Dental Hygiene Program's impending clinic move. However, she says it does *not* appear that the program will be operating out of its new clinical facilities at the time of its impending accreditation site visit which is scheduled for next spring.

The college's dental hygiene staff were involved in a number of professional development activities over the past year. Four staff are presently registered in an intensive Masters program designed specifically for CEGEP teachers. Charla Lautar completed her doctorate studies at the University of Calgary and the College's staff wish her all the best in her new endeavors. The College also welcomed 1987 John Abbott graduate, Lynn

Cummings, to its staff this year. Cummings arrived in January and hopes to remain on board for the 1994/95 academic year.

Faculty member Gisele Johnson joined CDHA's Education Standards Task Force. She was also the Association of Faculty of Dentistry (ACFD) representative on the Transitional Dental Hygiene Examining Board and will be the ACFD representative when the Official Board takes office in June 1994. Johnson was invited to participate as the ACFD representative in the CDHA workshop on Practice Standards for Dental Hygienists in Canada and she also attended CDHA's Research Conference in Niagara Falls last October.

Long says both staff and students are looking forward to a busy year ahead. She notes that CEGEP programs across Quebec will be undergoing a reform and although the Dental Hygiene Programs, per se, will not be affected, the core courses will be altered.



Algonquin College Nepean, ON

Algonquin College's Dental Hygiene Program Curriculum Coordinator Brenda Leggett reports that in August 1993 the program's faculty and students were settling into a new dental clinic. She says that the bright, modern facility meets the latest standards for infection control with features such as sensor-activated sinks, a custom air-filtering system and individual receptacles for bio-hazardous waste. In addition, an adjacent sterilizing area, a 30-seat dental laboratory, and a 50-chair classroom provide maximum efficiency for student learning.

Leggett says that last summer Algonquin's Computer Services Department helped to develop a computerized patient records management system for the clinic. As well as tracking clients for recall purposes, the program can identify and select patients by such characteristics as age and degree of difficulty. And, according to Leggett, this software has improved the care coordination of the 200+

clinic patients seen weekly between December and June.

The college's Dental Assisting students continue to be integrated into the hygiene clinics. Their experience includes infection control procedures, charting and other chair-side duties, and taking prescribed radiographs. She also notes that both Assisting and Hygiene students are encouraged to access the college's new Health Sciences computerized remedial lab. This 24-seat facility contains a variety of software to help students with course content such as medical/dental terminology and biostatistics.

During the past year faculty members at Algonquin have attended Provincial workshops dealing with prior learning assessment and multiculturalism in education. According to Leggett these topics are assuming increasing importance within the Ontario Community College system.

Dental staff at Algonquin recently welcomed the return of Debra Dufresne who rejoined Algonquin's faculty after an absence of several years during which time she completed a Masters Degree at Carleton University in Ottawa.

Durham College Dental Hygiene Program Oshawa, ON

Durham College's Coordinator of Dental Programs, Karen Tulk, says that during the 1993/94 academic year the college had twenty-three dental hygiene students working hard to complete the competencies they were challenged with. She also reports that the college's dental assistant students frequently chairside-assisted the dental hygiene students thus creating an atmosphere of professional teamwork.

The college's dental hygiene staff welcomed the opportunity to liaise with Ontario educators at two workshops in the past year—in August 1993 and again at Kempenfelt Centre in April 1994. The program's staff believe this type of forum provides Ontario educators with "valuable insights and the teamwork that benefits everyone including the students". Staff at the College of Dental Hygienists of Ontario have also made themselves available to educators by attending forums and clarifying changes in the practice of dental hygiene in Ontario. In addition to this, CDHA has invited Ontario educators to participate in future plans directly relating to the educational process and the develop-

ment of entry to practice standards for the profession.

Tulk says that this year's dental hygiene students were busy making presentations to community groups, gaining insight to alternate practice settings, and writing research papers on current trends in dentistry as part of their community health education. Two of the college's staff attended the CDHA Research Conference held in Niagara Falls in October 1993. The rest of the program's full-time staff attended the CDHO-ODHA May Convention in Toronto. She says staff are currently working hard to satisfy the requirements of General Education and Prior Learning Assessment that must be implemented into the Program by the fall of 1994.

Canadian Forces Dental Services School (CFDSS) Borden, ON

The Canadian Forces Dental Services School (CFDSS) offers a seven-month dental hygiene course with full accreditation status. Its candidates are military dental assistants who, by merit, are selected to attend the program.

A faculty of nine oral health professionals deliver the dental programs including two dental hygienists, two periodontists, one general dentistry specialist, one prosthodontist and three general dentists. In addition to offering a dental hygiene program, CFDSS trains laboratory technicians, dental assistants, repair technicians and it provides various continuing education programs for dentists.

Master Warrant Officer C.J. Bujold says the number of candidates selected for the dental hygiene program varies from a minimum of four to a maximum of eight students. The next course is scheduled to begin September 4.

Bujold notes that, as one may suspect from the length of the course, it is a fairly intensive program. The course curriculum covers all aspects of dental hygiene. The first half of the program focuses on theory although the students are also introduced to clinical skills. The second half of the program is dedicated to patient treatment with some theoretical subjects on the agenda. However the low number of candidates, a readily available patient population and the "hands-on" experience, ensures most students graduate. (According to Bujold, the challenge lies in the candidates' abilities to study for long hours and function with little sleep.)

George Brown College Toronto, ON

During the 1993/94 academic year fifty-three students were enrolled in George Brown College's dental hygiene program.

The program's coordinator, Evie Jesin, says the program embarked on an internal review program known as Quality Scan in February. She also reports that a videotape highlighting the college's dental hygiene program was produced this year.

According to Jesin, a number of changes in the program's curriculum were implemented this year, including a more hands-on orthodontic component as well as an integration of community health, dental health education and field placement.

Jesin and colleague Harriet McCabe were recently granted professional development leaves. McCabe will pursue further education in the BScD program at the University of Toronto and Jesin says she will investigate the development of a two-year dental hygiene program.

The College will continue to host its two-week dental hygiene refresher course in July. It will also offer a one-week clinical course to help candidates prepare for the College of Dental Hygienists of Ontario certificate of registration examination.

Seneca College North York, ON

Coordinator of the Dental Hygiene Program at Seneca College, Pat Johnson, says that 20 full-time dental hygiene and 50 full-time dental assisting students were enrolled at Seneca College during the 1993/94 academic year.

She reports that while last year the program's primary focus was its preparation for a successful accreditation review, this year faculty were able to redirect energies to several ongoing projects. She says that greater integration of the two programs continues to be a focus noting that collaborative clinics, introduced in 1991 as part of a curriculum review, were extended this past year. This approach provides both dental hygiene and dental assisting students with enhanced learning opportunities according to Johnson. She says another ongoing focus is the implementation of the dental hygiene process into the clinical curriculum. She also reports that the modification of clinical procedures and forms was a major activity during the past academic year.

Johnson says field placements (or practicums) continue to be a valued component of the college's dental programs. In the past year dental hygiene students had a one-week practicum in one of several regional hospital where they provided comprehensive dental hygiene services to a wide range of clients. They also spent time with the North York Health Department providing oral health education in local schools. Dental assisting students had a one-week practicum at the University of Toronto's Faculty of Dentistry, where they rotated through the varied dental clinics. Seneca's dental health students also participated in the celebration of World Oral Health Day on April 7 by preparing public displays which included materials previously developed for an Oral Health Fair.

Dental faculty at Seneca are now involved in two province-wide initiatives to improve access and quality. Other ongoing activities include the incorporation of intra-oral procedures into the full-time dental assisting curriculum. Faculty are also incorporating principles from the Regulated Health Professions Act (RHPA) — the new legislation regulating dental hygienists in Ontario — into the dental hygiene curriculum. Johnson says that the college's dental health programs are also preparing for a possible relocation to a new campus at York University.

Fanshawe College of Applied Arts and Technology London, ON

Fanshawe's significant strengths continue to be its relatively small student enrolment (18 dental hygiene students), its four enthusiastic and dedicated full-time faculty members, and its compact 8-chair clinic, so says Lynn James, Coordinator of Fanshawe's Dental Auxiliary Programs.

According to James, the Dental Hygiene Program's full-time staffing status has stabilized after a few years of transition caused by a combination of sabbaticals and retirements. James is the Coordinator of the Dental Auxiliary Programs (Dental Hygiene and Dental Assisting) while A-C Potter, a 1988 Fanshawe graduate, has been on faculty since September 1991 and Helen Symons, a 1984 graduate from Seneca College, is just completing the required two-year probationary period. A-C and Helen have cross-appointments with the Dental Assisting program and they enjoy a close working relationship with Laura Venema. During her 1992/93 sabbatical year Laura completed Fanshawe College's Dental Hygiene program. She continues to teach the dental assisting students

exclusively, however, it is anticipated that she will be integrated into the dental hygiene clinical program in the future.

James says that during the past two years there have been significant changes in the college's dental hygiene curriculum. The former approach of training technical skills has been replaced by an emphasis on dental hygiene education as a knowledge-based process. This process requires the student to be much more involved in assessments, analysis, decision-making, implementation and evaluation.

In spite of a heavy workload and the challenges associated with a compressed nine-month program, Fanshawe students support the program's philosophy and goals. James notes that this year's class was particularly cohesive. "Their mutual support is demonstrated daily through their clinical interactions, group projects and presentations and their overall commitment to the shared success of each member of the class," writes James.

According to James, Fanshawe's Dental Hygiene Program strives to achieve a collaborative working relationship based upon mutual respect and shared goals. She says this approach fosters a positive learning environment and enhances the students' success rate.

"As our profession matures dental hygienists must be both competent and confident in their abilities to provide client care in a more independent, responsible and accountable manner. We are proud of our graduates and we believe that they will be a credit to both Fanshawe and the dental hygiene profession," concludes James.

Confederation College Thunder Bay, ON

Gail Sargent, Coordinator of the Dental Hygiene Program at Confederation College says the program experienced yet another busy year with 16 dental hygiene and 30 dental assisting students. The faculty is comprised of three full-time and six part-time instructors.

Sargent says this year students enjoyed the challenges of new modes of delivery, including independent learning and 48 campus site visits. A variety of community oral health experiences were also organized, including visits to public schools, public health units, homes for the aged and a visit to the McKellar General Hospital. Students also developed needs assessment projects and grew in their

teaching abilities through placements and presentations. According to Sargent, the integration of oral health education and promotion will help students form foundations for developing community plans in the future.

Students also enjoyed refreshing new experiences in preventive dentistry and nutrition counselling through initial exposure to computer analysis of the client's health status and nutritional analyses. Guest speakers included Dr. Bill Hettenhausen, Y.T.F.L. foundation, Lucy Boduris, from J.O. Butler, Marsha Stein of Teledyne Waterpik and Dale Scanlan who lectured on implants. Sargent also reports that this year's students presented their periodontic and oral pathology projects utilizing a combination of intra-oral camera and phase contrast microscope videos.

Confederation College's dental hygiene students were also afforded a unique opportunity through a program jointly sponsored by the Canadian and Chinese Governments. Dr. Bui Foag Guo, a dentist from China, visited the program for the fall semester (three months). Sargent says Guo studied the Dental Hygiene program with the intention of implementing a similar program in Kunming, China and his presence provided students with an opportunity to learn more about dentistry in a foreign country.

St. Clair College of Applied Arts and Technology Windsor, ON

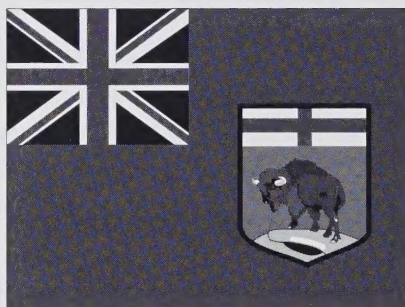
According to Sadie Hearn Coordinator of St. Clair College's Dental Hygiene Program, the 30 students enrolled in the dental hygiene program had a very productive and rewarding year. Hearn says the college's new sterilization preparation rooms proved to be a great asset to its clinical facilities and enhanced its established effective infection control procedures. She notes that being located adjacent to the restorative operatories, the area quickly became an established focal point in the clinic.

The college's dental hygiene students and faculty enjoyed participating in a few community service projects this year. In collaboration with the Windsor minor hockey league, a mouth guard clinic was organized and several youngsters from the Windsor-area received custom-made mouth guards. Dental hygiene students were thus given an opportunity to practise their impression-taking skills while the dental assisting students poured up the models and helped make the mouth guards for the players. Many students and faculty also participated in a preventive dental health display at the famous Colasanti's nursery and

greenhouse. Hearn notes that this activity put the participants' educational skills to the test since hundreds of visitors viewed the display. She says this activity also helped attract new clients.

According to Hearn, the program's revised clinic chart, which incorporates all phases of dental treatment planning, implementation and re-evaluation, is an added asset to the competency-based clinical component of the dental programs. "This comprehensive chart exemplifies a format for thorough record-keeping," says Hearn, adding that, innovative teaching techniques continue to enhance the academic portion of the program. Hearn notes that several problem-solving sessions have been incorporated into the dental assistant radiology course and it is anticipated that the radiology skills of its graduates will improve.

According to Hearn, the academic challenge to be faced in the upcoming year will be the integration of more general education courses into both dental programs at St. Clair College.



University of Manitoba School of Dental Hygiene Winnipeg, MB

Ellen Brownstone, Director of the University of Manitoba's School of Dental Hygiene says many faculty members at the school continue to move onward and upward: Professor Marnie Forgay returned from a one-year study leave on August 1, 1993. During her absence she was associated with the Canada/Mozambique Project for Training Primary Oral Health Care Personnel. Marnie is currently serving as Chair of the Allied Dental Education Programs Committee (a committee of the Commission on Dental Accreditation) and was appointed as CDHA's First Vice President at its Annual Meeting held last June in Ottawa. Marnie will be resigning from the School's faculty effective August 1, 1994 and Brownstone says her co-workers wish her much happiness in her future plans.

Professor Bonnie Trodden received a PhD (Anthropology) in October 1993 from the University of Manitoba while Brownstone herself received grants from NHRDP and CFDE in support of the CDHA Professional Research Conference held in Niagara Falls in October 1993. Professor Brownstone has also been appointed to serve as a member of the recently established National Dental Hygiene Research Advisory Panel (funded by the Bureau of Health Professions, U.S.). The panel is devoted to developing a National Dental Hygiene Research Agenda and a Centre for Dental Hygiene Research.

Professor Laura MacDonald spent the past year with her family in North Carolina and will be returning to the School in the fall of 1994. Part-time faculty member, Lorraine Glassford, served as President of the Manitoba Dental Hygienists Association during 1993/94. She was succeeded by Nancy Hughes who is President for the 1994/95 term. Signe Arason was elected as President of the Dental Auxiliaries Association of Manitoba (DAAM) for a three year term. Charlene Gagnon resigned from the School last summer and moved to Ontario where she assumed a full-time position in public health and a part-time position at Cambrian College in Sudbury. U of M's School of Dental Hygiene also welcomed two new faculty members this year: Lorraine Glassford and Cindy Isaac; and returning member Professor Mickey Wener.

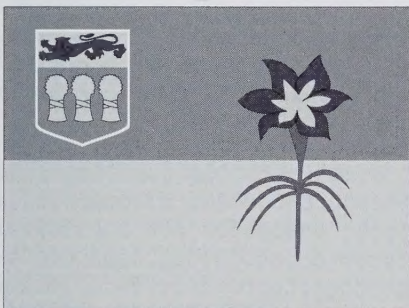
Brownstone reports that the School was proud to learn that two of its 1993 dental hygiene graduates were awarded the Aqua-Fresh Student Scholarship Award (1993). Christy Cessford and Natasha Kravtsov, were awarded the scholarship for a research study they completed during their second year of studies entitled, "Restorative Dental Services and Manitoba Dental Hygienists".

In November 1993 the School conducted a faculty development workshop on Theory Development facilitated by Professor Denise Bowen, Head of the Dental Hygiene Program at Idaho State University. The workshop focused on applying the Dental Hygiene Human Needs Conceptual Model to the clinical teaching program. In January 1994 visiting Professor Janice Pimlott, Head of the Dental Hygiene Program at the University of Alberta, made a presentation to faculty on oral care products, topical chemotherapeutics, fluorides and caries risk assessment.

The School undertook a minor (self-study) curriculum review during 1993/94 to assess the impact of major curriculum and admission changes which were made a few years

ago. In addition, the School, in conjunction with the Manitoba Dental Hygienists Association, conducted a "Membership Retention Survey" of non MDHA/CDHA members with the aim of developing strategies to increase and encourage support for professional dental hygiene organizations among dental hygienists and dental hygiene students in Manitoba.

This year U of M's dental hygiene students participated in various externships: on a mobile dental van, at an institution for the mentally and physically handicapped, at a community health centre, and in a municipal dental program in Winnipeg. During CDHA's National Dental Hygiene Campaign, senior students conducted oral health wellness programs at several local workplaces (Manitoba Telephone System, Great West Life Insurance, and Health Sciences Centre General Hospital) while junior students prepared written scripts on oral health topics for a local "health telephone line" program. There were 26 students enrolled in the 93/94 Dental Hygiene program, while 23 students continued in the second year program.



**Saskatchewan Institute
of Applied Science Technology
(SIASST)
Regina, SK**

According to Noel Selinger, Program Head, Dental Hygiene at Saskatchewan's Institute of Applied Arts, Science and Technology (SIASST) the most exciting recent development in the Dental Hygiene School is the approval of a Direct Entry Two Year Program. She says it's been a long struggle through the SIASST approval process but the time and effort was well worth it and gives credit to Diane Moore for developing a great implementation proposal.

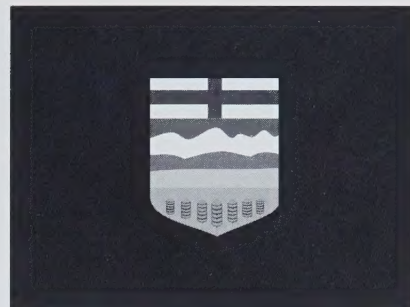
The two-year program will allow Grade 12 graduates access to Dental Hygiene education.

This means that people wishing to pursue a career in Dental Hygiene will no longer have to be a Certified Dental Assistant with two years of experience, or a Dental Therapist, before they can apply to become Dental Hygiene students. Course credits for previous education will be granted on an individual basis to the Assistants and/or Therapists enrolled in the new program. Selinger says that the two-year program will also increase the portability of SIASST graduates. They will be eligible for licencing in provinces that require graduation from a two-year program.

Dental Hygiene education in all other provinces, with the exception of Ontario, is two years in length. Some Canadian Dental Hygiene schools require a prerequisite one year of University Arts and Sciences, which usually consists of one class in English, Psychology, Sociology, Science, and one elective. The SIASST program will accept applications from Grade 12 graduates who have two sciences. ** (**minimum 60% average Grade 12 or Adult 12, or Adult admissions; with Biology 30 or 12, and one additional science 30 or 12.) SIASST's program will include courses dealing with Sociology and Psychology, and a course in Communication Skills: Reading and Writing. To date, the exact admission criteria have not been established, but according to Selinger, the department is committed to making the process as fair as possible for everyone who applies.

During the 1993/94 academic year, SIASST had thirty-six students enrolled in its Dental Hygiene II Program (DH II) and twenty students in its Dental Hygiene I Program (DH I). In 1993, due to the decrease of Saskatchewan employment opportunities for DH graduates, the official number of seats in DH II was reduced from thirty to twenty-four. The additional seats offered in the 93/94 year were due to a training contract with the Province of Manitoba. Manitoba's Dental Plan was canceled in June 1993 and SIASST's additional students are unemployed Manitoba Dental Therapists who are furthering their education. The twenty students in DH I are all Certified Dental Assistants who will join the Dental Therapists in DH II in September 1994.

SIASST plans to initiate its first year of the Direct Entry Program in September 1994 with twenty-four students. At the same time, it will be delivering the last DH II program in its present format. The DH I program it currently delivers will also be the last one in its present format.

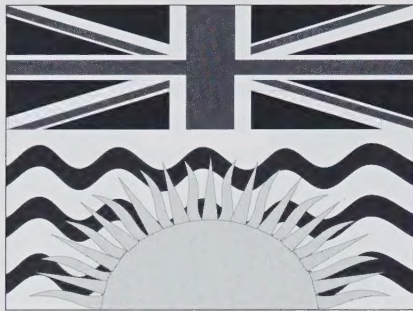


**University of Alberta
Division of Dental Hygiene
Edmonton, AB**

The University of Alberta's Dental Hygiene graduating class of 63 students completed a challenging year, says Janice Pimlott, Chair of the Division of Dental Hygiene at the University of Alberta. The year culminated with student research project presentations at the Edmonton District Dental Symposium and at the Faculty of Dentistry Research Day. And, according to Pimlott, the calibre of the research efforts on display was commendable and recognized by many.

During the 1993/94 academic year the program welcomed ten new members to its part-time academic staff: Bernice Aebly, Julia Borrelli, Donna Comeau, Lois Goertz, Lorne Kamelchuk, Charla Lautar, Ritchie Mah, Shannon Mitchell, Susan Skuba and Christine Sutor. In addition, two part-time faculty were recognized for their valued teaching contributions. Barbara Gitel was promoted to Clinical Associate Professor and Sandy Cobban was promoted to Clinical Assistant Professor. Pimlott says that staff are also proud of the achievement of their colleague and friend, Charla Lautar, who recently earned a PhD from the University of Calgary. According to Pimlott, Charla is currently the program's "most traveled" faculty member — she commutes from Calgary two days per week.

Pimlott reports that, without a doubt, the greatest stress faced by staff at the University of Alberta's Dental Hygiene Program during the past academic year was the University's proposal to close the dental faculty eliminating both the dentistry and the dental hygiene programs. Nonetheless, Dental Hygiene staff say they are optimistic it can be successfully demonstrated that dental and dental hygiene education are important to the university. They say they will leave "no stone unturned" in their efforts to convince the university of the value of both of these programs.



Vancouver Community College Vancouver, BC

According to Susanne Sunell, Dental Hygiene Program Coordinator at Vancouver Community College (VCC), the 'travel bags' of dental hygiene faculty at the College saw lots of action this year! Many attended CDHA's 4th Annual Professional Conference in Niagara Falls because it focused on 'research' and the proximity of the Association of Canadian Faculties of Dentistry (ACFD) in Saskatoon and the American Association of Dental Schools (AADS) meeting held in Seattle also attracted VCC faculty participants. Members of the faculty say they have enjoyed "both gastronomic and neural stimulation" over the past year.

Sunell says that the diagnostic decision-making model presented by Darby and Walsh at the Niagara Conference resulted in its integration into the Dental Hygiene program's first year curriculum and clinical activities. She says staff are interested in sharing ideas with other faculties working with this model or planning to integrate it into their program.

According to Sunell, there will be a new look in 'clinical fashion accessories' at VCC in the future: an on-going study focusing on the principles of balanced posture through the integration of optical scopes into dental hygiene practice will soon be completed. Over the past eight months, three of the second-year clinical faculty have been evaluating scopes with a customized declination angle and 2.5 magnification. Sunell says their response to the scopes has been very positive and they are now investigating strategies for introducing the scopes to both faculty and students.

Sunell says members of VCC's dental hygiene faculty have also been extensively involved in continuing education projects at both the professional and personal level. Tricia Hughes and Pat Robertson are on

educational leave until September 1994. Pat graduated in the spring with a BDS from UBC while Dianne Stojak and Tricia Hughes are pursuing their BAs in Adult Education through a joint venture of VCC and the University of Alberta. In addition, Pat Robertson and Lynn Smith continue to provide continuing education courses in radiology, with their next presentation to be delivered at the Fédération Dentaire Internationale (FDI) conference being held in Vancouver this October. Ginny Cathcart is on the speaker's circuit with the topic of antimicrobial agents. Dianne Stojak is a sessional instructor of a problem-based learning course implemented by Dr. Chris Clark at UBC. Susanne Sunell, who has been involved in continuing education ventures related to diagnostic models and performance simulation in dental hygiene care, will be taking a one-year leave to complete a Master of Arts in Higher Education at the University of British Columbia. Linda Maschak will also be taking a one-year leave for personal and professional development. Ruth Lunn, Doug Nann and Francis Tavares continue their involvement with UBC's Local Anaesthetic Course for Dental Hygienists and Keith Milton continues his doctorate work at UBC's Faculty of Medicine.

In 1991 VCC sponsored a workshop for all its dental hygiene program instructors and members of BCDHA. The workshop, which examined the impact of self-regulation on dental hygiene curriculum, was facilitated by Jane Fulton. Sunell says a report generated after the workshop is currently being revised to address the reality of self-regulation in British Columbia.

In November, VCC's Dental Hygiene program was granted full accreditation status for seven years. Faculty say they attribute this excellent rating to the visions and ideas shared by many dental hygiene educators across Canada over the years.

University of British Columbia Vancouver, BC

The University of British Columbia's Faculty of Dentistry offers a post dental hygiene diploma degree completion program that leads to a Bachelor of Dental Science degree with the completion of 60 credits of course work. Most credits are achieved through participation in the program's core courses which all students are required to complete. However, once the core credits are earned, students can focus on areas of interest in community oral health care, advanced

clinical practice or allied dental education to earn additional credits to bring their total to 60.

During the 1993/94 academic year, five full-time and seven part-time students were enrolled in the program. In May 1994 Mandeep (Mandy) Hayre, Patricia Robertson and Judy Somlyai were the first to graduate with a UBC Bachelor of Dental Science (BDS) degree. Debbie McCloy and Terri-Lynne Martin completed their first year of study in the program. Rita Chu and Barbara Drewry are into their second year as part-time students, and Mary Lou Burleigh, Mary Findlay, Jo Gardner, Carolyn King and Karen Martel are in their first year of part-time studies.

Jo Gardner, an instructor in the BScD Program says students from across the country enroll in this unique program: to date there have been candidates from various areas in British Columbia, Nova Scotia, Alberta, Manitoba and other places in between. She says the program offers a lot of flexibility and many candidates work part-time in private practice, education or community health while studying. Others are able to study while maintaining family commitments. Differences in age, level of education, permanent place of residence, and family experiences among the candidates ensures an interesting mix of individuals.

Dental Hygienists may also be interested to learn that UBC's Faculty of Dentistry offers a masters program that leads to a Master of Science in Dental Science. Dental Hygiene colleagues, Lynn Guest and Shafik Dharami are currently enrolled in this program. Their areas of interest are community health and oral health promotion respectively.

College of New Caledonia Prince George, BC

Instructor Barb Maillot says the 1993/94 academic year at the College of New Caledonia proved to be a challenging and rewarding year for the graduating Dental Hygiene class. According to Maillot, the year provided students with numerous opportunities to sharpen their clinical skills, and work as a team with each other and the staff.

According to Maillot, this year's graduating class undertook numerous projects. Students participated in the National Dental Hygiene Campaign (NDHC) by setting up table displays at the College and explaining the roles and responsibilities of a Dental Hygienist.

This activity gave the rest of the College a chance to learn more about dental hygienist roles outside the clinical environment. Another NDHC activity saw the "toothfairy" (Leah Messenger) and Barb Maillot pay a visit to the campus day-care to distribute toothbrushes and provide a toothbrushing demonstration. Maillot says the "toothfairy" was a hit!!

Maillot says that just before Christmas the dental hygiene students learned that personal care items were in need at the local Transition Home, a safehouse for battered women and their children. She says students coordinated a drive to help and with the support of J.O. Butler and staff at the college's Division of Dental Studies, donated toothbrushes, floss and other needed items.

Dental Health Month was also a busy time. Students presented the last baby born in the month of April with a "baby basket" containing dental care information and items for baby and mom. Other projects undertaken included a visit to the Paediatric Ward at the Prince George Regional Hospital where the Canadian Dental Association's 'Smiling Bob' entertained the children while dental hygiene students distributed toothbrushes and fielded questions.

Maillot notes that although the past year was a busy one, there was still time for fun. She says dental hygiene students made an environmental donation to the College of New Caledonia this year. Students arranged to have a blue spruce tree planted outside the Dental Building for staff and students to enjoy. They hope that while enjoying the view, the Class of 1994 will also be remembered.



Students in the dental hygiene program at New Caledonia participated in a table display at the College during National Dental Hygiene Campaign. (l-r) Dental hygiene students Cheryl Desautels and Melanie Donaldson

Camosun College Victoria, BC

According to Marge Reveal, Coordinator of Dental Programs at Camosun College, the past year has brought many changes to the college's Dental Hygiene Program. Reveal says that as of September 1994 the college will administer its Dental Programs in conjunction with the Nursing Program to increase efficiency and cut costs. There will also be one coordinator, rather than two, for all three programs. A Program Leader(s) will replace three dental team leaders with less release time for administrative duties. In addition to these administrative changes, the

Dental Hygiene program will increase enrollment by two, from 24 to 26 students. (The Dental Assistant program increased from 40 to 42 in 1993.)

After receiving a grant from the British Columbia Centre for Curriculum Development the college undertook a study to determine potential areas of integration between its dental assistant and dental hygiene programs. The research was conducted this year and a final report was completed in June. Investigators evaluated prior learning assessment and the feasibility of core course development within the two programs. Reveal says there are no plans to establish a "one + one" program, such as Ontario now provides, although a degree of integration is a likely outcome of the study.

This year the College's Dental Hygiene and Dental Assisting students participated in Oral Health Day activities in conjunction with practicing Dental Hygienists and Certified Dental Assistants. In recognition of Oral Health Day 1994 and the Commonwealth Games (being held in Victoria this August) an athletic equipment exchange was also undertaken by the students. Students also helped distribute oral care aids and educational materials to the public in recognition of Oral Health Day.



The "toothfairy" (Leah Messenger) and friend Barb Maillot at the College of New Caledonia's day-care.

Subepithelial Connective Tissue Grafts

By:

Leanne D. Carlson-Mann, SDT, RDH

History

A 37-year old female presented with localized gingival recession on the lower lateral incisor and canine. Although these conditions had been in existence for approximately ten years, the patient complained that recently she had noted a slight increase in sensitivity to cold and air. The patient has a history of good oral hygiene and dental compliance. (Figure 1)

Examination

The patient is in excellent health and is dedicated to a strict fitness and dietary regime. Recall examinations reveal a progressive slight increase in the recession measurement from CEJ to the marginal facial gingiva, minus probing depth. The marginal tissue is coral pink with knife edge margins. Upon examination, there is no bleeding on probing and probing depths are approximately 2 mm. There is satisfactory occlusion with no tooth mobility.

Clinical Diagnosis

Progressive marginal recession predisposed by facial position of teeth with thin labial bone and minimal attached gingiva. The recession is precipitated by vigorous tooth brushing.

Discussion

As hygienists, we see gingival recession on a regular basis and as responsible professionals, we advise our patients of their situation and when necessary refer to a periodontist for a variety of grafting procedures.

At every recall the recession should be measured from a fixed point. The quantity of the remaining attached gingiva is one of the deciding factors when a graft placement is under consideration. The measurement of the remaining attached gingiva is calculated by subtracting its probing depth from its recession. The sensitivity, esthetic concerns and the patient's ability to clean the area comfortably are also deciding factors. The gingiva should always be augmented when restorative work is planned in areas of limited attached tissue.



LEANNE D. CARLSON-MANN, SDT, RDH



Figure 1. Before grafting procedure.

The Subepithelial connective tissue graft can be used for coverage of single or multiple denuded root surfaces. This procedure is designed to achieve maximized blood supply to the grafted area. The overlying partial thickness flaps, interdental papilla, and the recipient bed provide the nutrients and vascularization needed to favor large areas of exposed root or multiple areas of recession.

Treatment Options

1. Thick free gingival autograft.
2. Subepithelial connective tissue graft.

Treatment of Choice

Subepithelial connective tissue graft because:

- a) less pain in palatal donor site
- b) more predictable blood supply to recipient site

Treatment Procedures

The procedure is as follows: the palate must be of sufficient thickness to provide a graft of approximately 1 to 1.5 mm. After the root has been conditioned and planed, a horizontal incision is made slightly coronal to the CEJ in the interdental papilla adjacent to the denuded root. The following incision is sulcular to connect the interdental incision while the vertical incisions are extended apically. The graft is sutured coronally to the recipient bed or interdental papilla and secured laterally by suturing the underlying periosteum. The partial thickness flap is then sutured over the connective tissue graft. Early healing shows the grafted site much thicker than adjacent gingiva. However, with time it usually blends in very well with adjacent gingiva. It is only on rare occasions that gingivoplasty is necessary to correct thickness. (Figures 2,3,4,5)

(This procedure was first reported by Dr. L. Langer and Dr. B. Langer in 1987. It may be of interest to note that Dr. L. Langer was a hygienist first and went on to specialize in periodontics and now practices with her husband Dr. B. Langer in New York, NY.)

Results of Treatment

As seen on figures 1 and 6, 4 mm of attached tissue was achieved. Probing depths remained at 2mm. Tissue is now bound down with good color and contour. The sensitivity has now disappeared, greatly facilitating the patients new gentle home care procedures. (Figure 6)

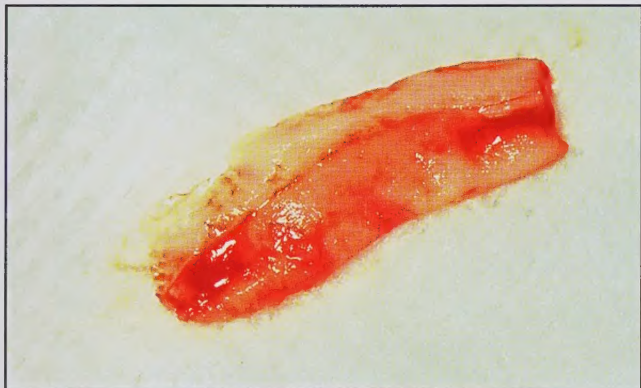


Figure 2. Subepithelial corrective tissue graft taken from palate.



Figure 3. Sutured donor site on palate.



Figure 4. Recipient bed.

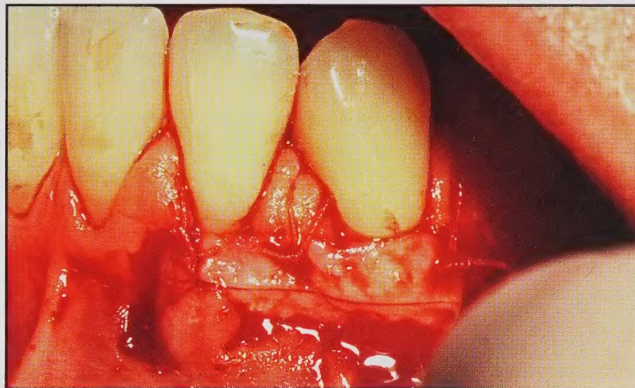


Figure 5. Graft in place and initial sutures.



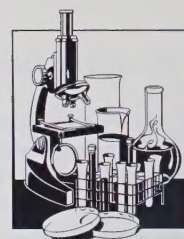
Figure 6. 90 days post graft procedure.

Leanne received her diploma in Dental Therapy in 1981 and a diploma in Dental Hygiene in 1982 from WIAAS in Regina, Sask. She has been employed with Dr. C. G. Ibbott, a periodontist in Regina, since graduation. Leanne received her dental implant training at the University of Washington in 1988 and has been extensively involved with implant procedures. As well as teaching and providing continuing education courses (primarily in Western Canada), Leanne teaches a dental implant class to the second year dental hygiene students at SIAST. Students this year were the first to receive an accredited hands-on prosthetic course in cooperation with Nobelpharma. Leanne has published a number of articles in *Probe*, the *CDA Journal* as well as co-authoring articles for various international journals.

Case Studies are presented for the interest of our members. However, CDHA is not endorsing any specific interventions.

We welcome submissions of this nature from our members to encourage an exchange of information.

Oral Pathology



1. The "white line" commonly observed and clinically evaluated on the buccal mucosa, which extends from anterior to posterior along the occlusal plane is
 - a) leukodema
 - b) leukoplakia
 - c) lined alba
 - d) lichen planus
2. Leukodema is considered a variant of normal and is observed clinically as a diffused grey to white form on the buccal mucosa that gives an opalescent character to the tissue. It is found most commonly in
 - a) Whites
 - b) Asians
 - c) Native americans
 - d) Blacks
3. An increase in the size of an organ or tissue resulting from an increase in the number of its cells is termed
 - a) hyperemia
 - b) hyperplasia
 - c) inflammation
 - d) hypertrophy
4. Which of the following would not occur on the gingiva?
 - a) irritation fibroma
 - b) pyogenic granuloma
 - c) giant cell granuloma
 - d) epulis fissuration
5. The initial response of the body to injury is always the process of
 - a) immunity
 - b) inflammation
 - c) repair
 - d) hyperplasia
6. A patient presents with loss of tooth structure on the labial surfaces of the anterior teeth and reports a high concentration of acidic foods in the diet. You would suspect
 - a) abrasion
 - b) erosion
 - c) bruxism
 - d) attrition
7. The process of phagocytosis directly involves the
 - a) ingestion of foreign substances by white blood cells
 - b) plasma fluids and proteins entering the surrounding tissues
 - c) white blood cells displaced to the blood vessel walls
 - d) white blood cells attaching to the blood vessel walls
8. Desquamative gingivitis may be seen in
 - a) cicatricial pemphigoid
 - b) pemphigus vulgaris
 - c) lichen planus
 - d) all of the above
9. The most common cause of the radicular cyst is
 - a) caries
 - b) trauma
 - c) malignant infiltration
 - d) food impaction
10. The most common intraoral location for salivary gland tumours is the
 - a) lower lip
 - b) buccal mucosa
 - c) palate
 - d) anterior tongue
11. Neoplasia involves
 - a) an irreversible change that results in an uncontrolled multiplication of cells
 - b) an abnormal proliferation of cells in response to tissue damage
 - c) a controlled proliferation of cells
 - d) a normal arrangement of proliferating cells
12. In dentinogenesis imperfecta type II, teeth have roots that are
 - a) larger than normal
 - b) normal in length
 - c) markedly brittle
 - d) shorter than normal
13. Which of the following is not a characteristic of HIV associated periodontal disease?
 - a) pain
 - b) minimal bone loss
 - c) spontaneous bleeding
 - d) interproximal necrosis
14. Oral candidiasis
 - a) is an early sign of underlying immunodeficiency
 - b) is always a white lesion
 - c) occurs only on the tongue
 - d) is rarely associated with HIV infection

Answers:

- | | | |
|--------|--------|--------|
| 1. c) | 2. d) | 3. b) |
| 4. d) | 5. b) | 6. b) |
| 7. a) | 8. d) | 9. a) |
| 10. c) | 11. a) | 12. d) |
| 13. b) | 14. a) | |

Reference: Oral Pathology for the Dental Hygienist, Ibsen and Phelan, W.B. Saunders Company, Harcourt Brace Jovanovich, Inc., Philadelphia, PA Copyright 1992.

This self-assessment test was submitted by Master Warrant Officer Claude Bujold, RDH, Senior Hygiene Instructor, Canadian Forces Dental Services School, Canadian Forces Base Borden, Borden, Ontario

National Dental Hygiene Campaign 1994

October 16-23



Behind every great smile....

CDHA
ACHD

The Canadian Dental Hygienists Association
L'Association Canadienne des Hygiénistes Dentaires

personal and professional dental care

En arrière d'une sourire éclatant... le soin dentaire personnel et professionnel

From original material developed by the B.C. Ministry of Health

Canadian Dental Hygienists Association

announces its

6th Annual Professional Conference

The Public

The Practitioner

The Profession

Halifax, Nova Scotia

June 16-18, 1995

Nelson, B.C.

We are looking for a Dental Hygienist to join our progressive, quality-oriented practice in beautiful NELSON, BC.

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Annie Kammerzell-White at **(604) 352-5012**, at the office of John Snively, Nelson, BC.

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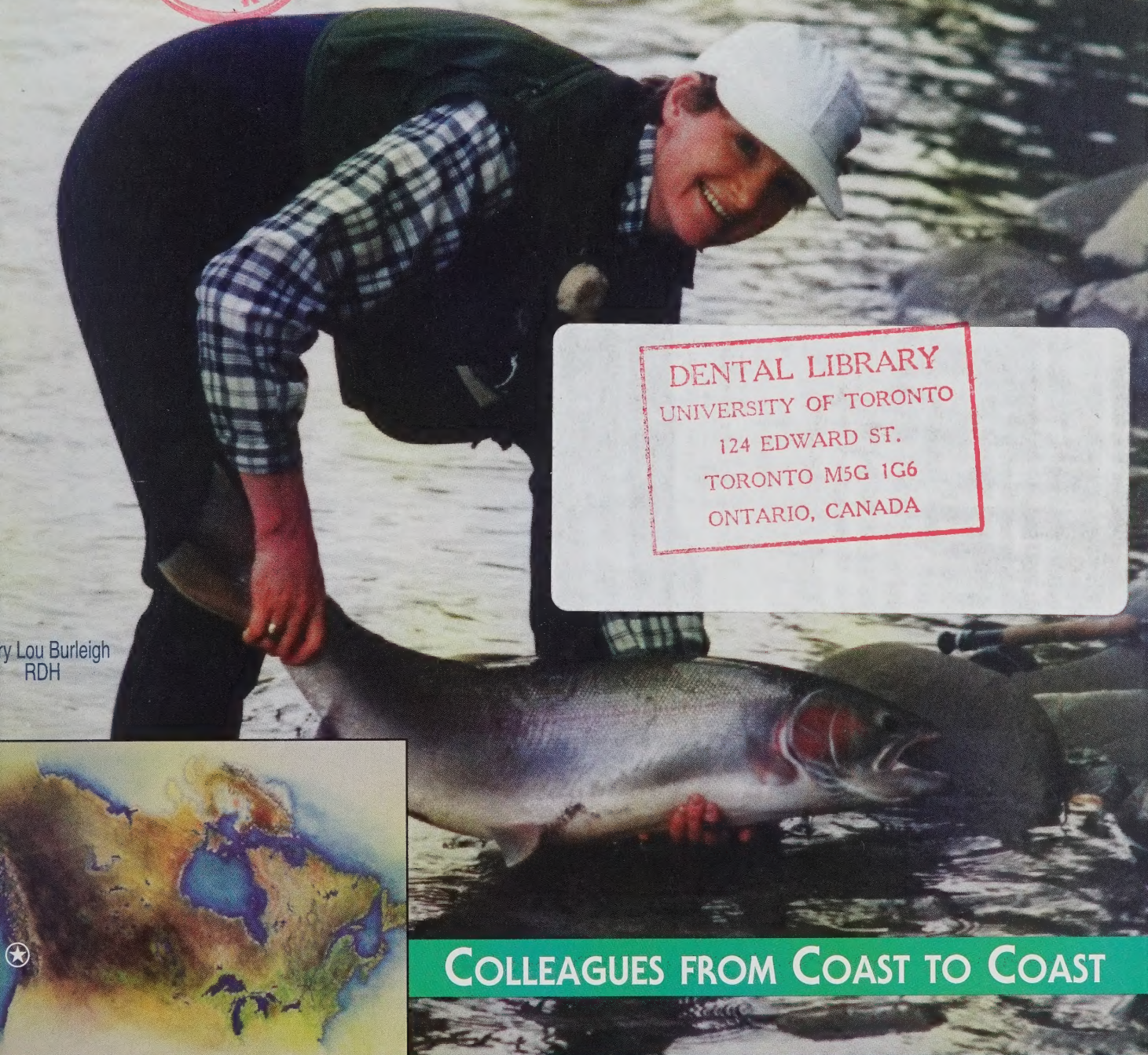
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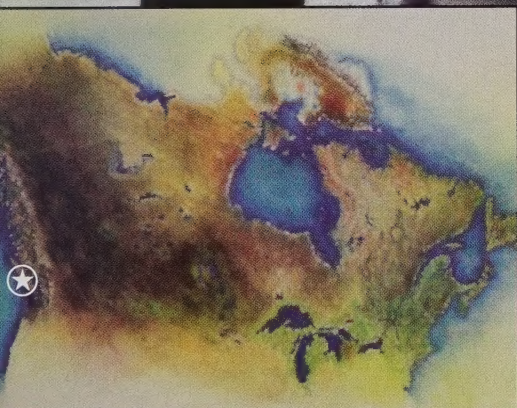
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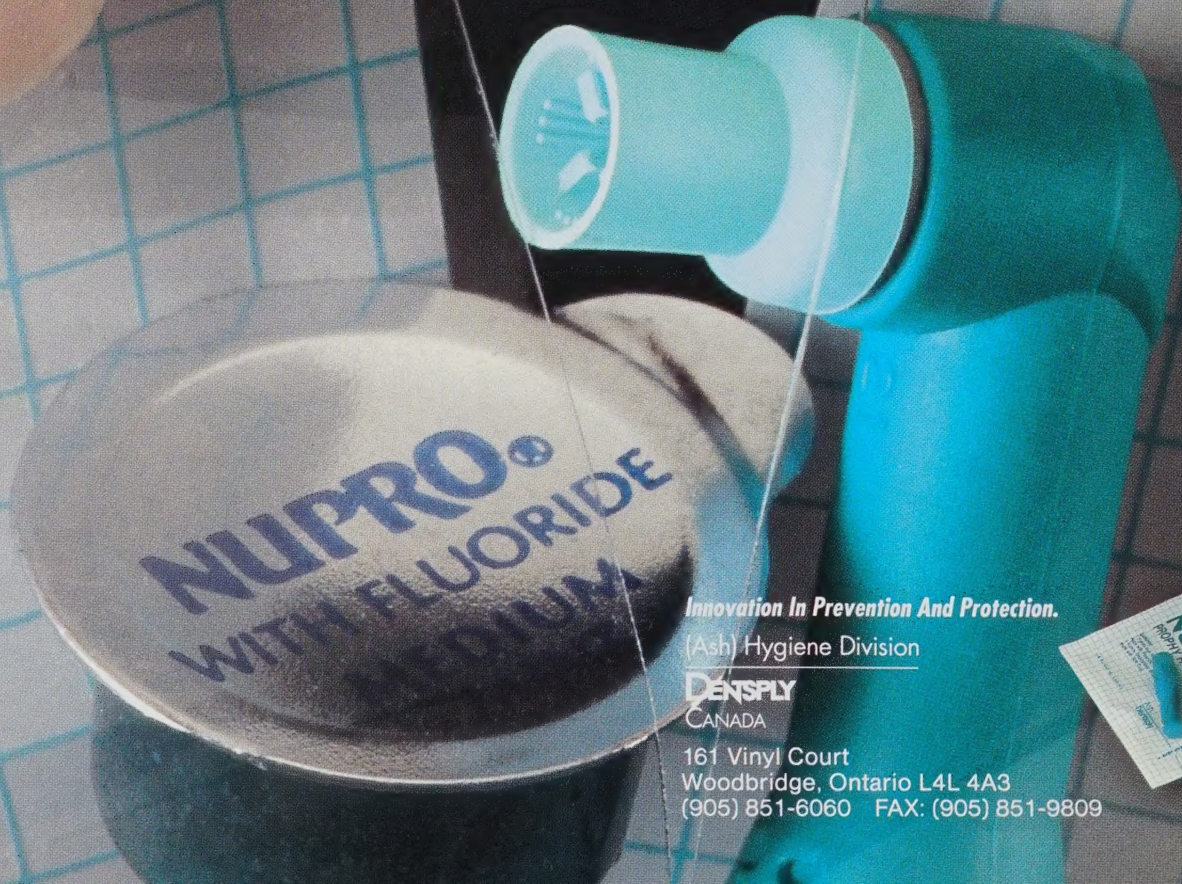
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Happy 30th Birthday CDHA — and Welcome to the ‘Big League’!

By:
Janice Edgar, BJ

It's been just over a year since I joined CDHA as its Director of Communications and although that includes a six-month maternity leave, the nine months I have been in the office have given me an excellent opportunity to take a look at the profession, and the Association, from a unique perspective. Not being a dental hygienist, I've been looking at the profession from the outside-in and I'd like to take this opportunity to share some of my findings with you.

Did you know that you belong to one of the most progressive and dynamic health care professions in the country? The Canadian Dental Hygienists Association is a mere thirty years young and it has transformed dental hygiene from a 'semi-profession' to one that is recognized as a separate and distinct profession in its own right. That is, in my humble opinion, an incredible achievement!

But, do you realize what the transition to professional status demands from you, as a member of the profession? I know the 'movers and shakers' of the Canadian Dental Hygienists Association understand the implications of self-regulation but I am not so sure all its members do. I believe it is the Association's responsibility to ensure they do, so they can function accordingly. The Association attempts to educate its members about the responsibilities they must accept as they move towards professional status through three key vehicles currently housed under the Association's communications wing: this journal, the Association's newsletter and the annual professional conference. However, unless you are attending the annual professional conference on a regular basis, reading the information we provide in the journal and reading your newsletter I would suggest we are not doing a good enough job. It is one thing to go through the motions to produce the vehicles for communication — it is quite another to ensure their quality is so impeccable that our members would feel irrepressible guilt for not utilizing them

in an effort to maintain their professional integrity.

While attending my first CDHA conference this June in Saskatoon I was absolutely mesmerized by the energy, enthusiasm, dedication and commitment the dental hygienists in Saskatoon displayed towards the profession. Perhaps I noted this because my seven day stay included attendance at CDHA's plenary session for its board members, council meetings, the annual board meeting, a president's forum, a legislative forum, the annual awards dinner, the president's reception, and an editorial board meeting, in addition to all the conference sessions. But nonetheless, I can assure you, my time in Saskatoon convinced me that you belong to a profession that is growing faster than Ben Johnson can run (even with the help of steroids). You have dedicated and capable members of the profession steering you into the future.

Canada's Dental Hygiene profession is becoming a force to be reckoned with: it is a fundamental part of the nation's primary health care system. It will continue to play an even greater role in keeping the public healthy because its approach to health makes good economic sense. By encouraging preventive oral health care approaches and enabling the public to take responsibility for their oral health status the dental hygiene profession can, and will, reduce health care costs in Canada. But, in order to do this, each and every dental hygienist out there must be committed to accepting full responsibility for doing the job of a professional. And every professional I respect, particularly in the health field, spends a great deal of effort keeping up-to-date and informed about the technological advances, scientific research and new ideas being generated to help them, not only to do their job, but to do it better.

You owe it to your profession to keep informed. One way to do that is by reading (and contributing to) the scientific journal

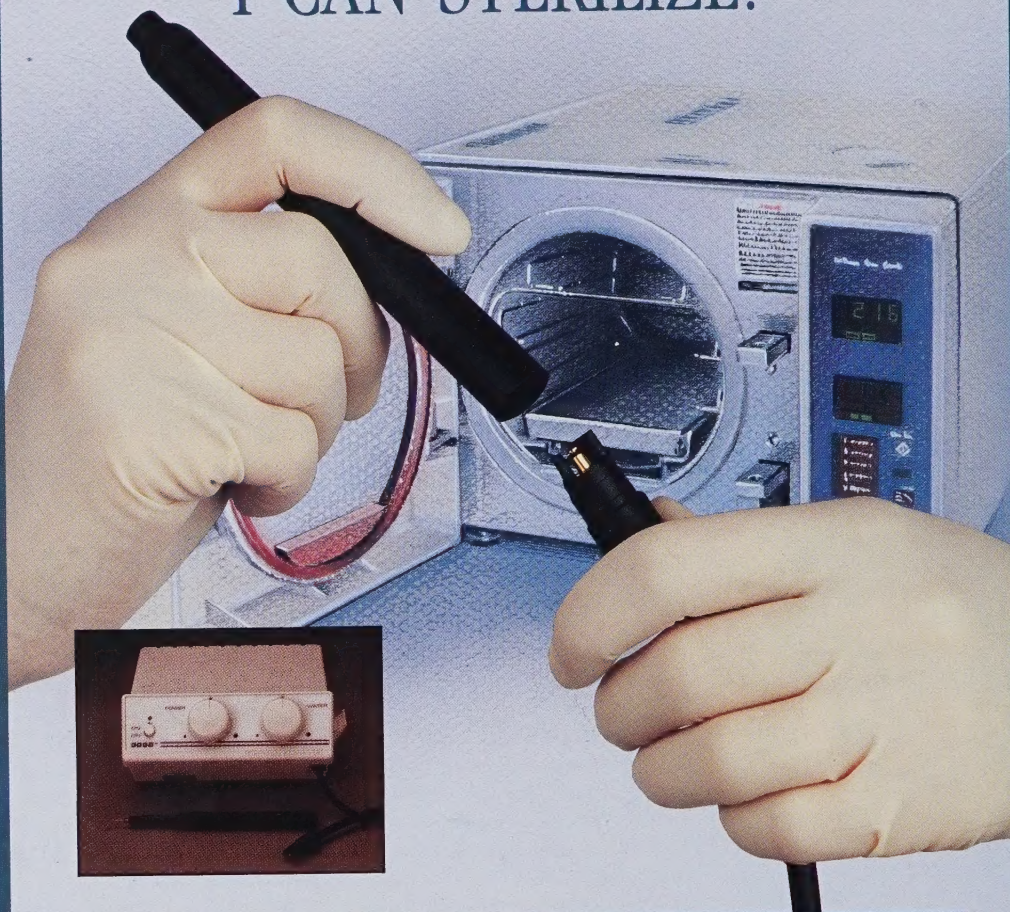
your professional association publishes. Another way to keep informed is by making every effort to participate in continuing education opportunities. And, my experience at CDHA's 5th Annual Professional Conference taught me that the learning that occurs at this particular event is by no means limited to the lecture rooms. The entire facility CDHA occupied in Saskatoon was charged with creativity and ideas focused on the dental hygiene profession. The exchange of information extended far beyond the scientific sessions, it could be found taking place in the hallways, the bathrooms, the lobby, the private hotel rooms...anywhere where there was more than one participant communicating, one discovered new information and ideas about the profession being exchanged — and that, to me, is *exciting* — what isn't so exciting is that of a membership of more than 6,000, only 230 participated in this incredible opportunity.

Ever since I arrived at CDHA last April I knew there was a great deal happening with the dental hygiene profession, but I wasn't able to nail it all down until I 'lived it' at the professional conference. In Saskatoon the 'spark' I had seen flickering over the past 15 months was ignited and an explosion of ideas followed. I am confident I was not the only participant who left Saskatoon charged with new enthusiasm and energy to conquer the mountains of work ahead. (And I am not even a member of the profession!) For this reason I urge you to become an active member of your professional association — it needs you as much as you need it.

You know, I had always felt the pulse of energy at CDHA but only while participating in its annual professional conference was I able to identify the location of the heartbeat. And what a wonderful discovery it was. CDHA is a mere thirty years young and it's ready to let go of the apron strings to stand on its own.



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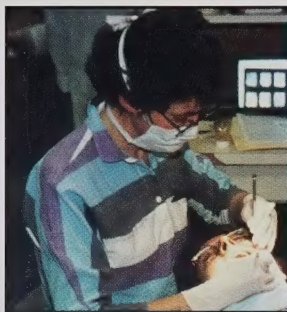


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COVER

This issue's cover features Mary Lou Burleigh, a 1990 graduate of the dental hygiene program at Vancouver Community College, engaged in her favourite hobby, fly-fishing for steelhead. Mary Lou currently works in private practice in Smithers, BC and is a part-time student in the Bachelor of Dental Science Program (Dental Hygiene) at the University of British Columbia. She is also an active member of the Steelhead Society of British Columbia, an organization dedicated to the preservation of wild fish and their habitat.

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L'Association Canadienne des Hygiénistes Dentaire

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All CDHA members are invited to call CDHA's Central Office, toll-free, with their questions/inquiries:

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We look forward to serving you.

Looking for a way to enhance patient compliance?

Here's an inside tip.

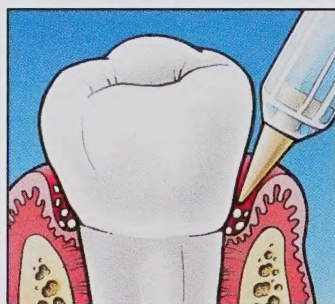
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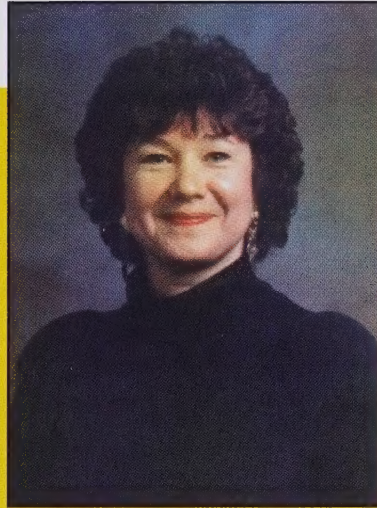
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Teledyne Water Pik

NOW is the time. . .

You wake up in the morning and it's a quarter to one, you want to have a little fun, you brush your teeth..." Do you recognize this line? It's a line from a Raffi song many of us sing to children while encouraging them to brush because we want them to experience brushing their teeth as a *fun* activity. Later we encourage brushing by explaining the health-related virtues: prevention of tooth decay, etcetera. Older individuals get an even more detailed explanation of the disease process and prevention when they visit us for care and information. We recognize and take our responsibilities seriously, ensuring our clients, both young and old, are given the information and taught the techniques they require to best care for their oral health. We promote the individual's responsibility for daily care, recognizing it as the most significant determination of oral health. As significant as professional care is, we recognized that *daily home care* is the key to a healthy mouth.

I don't think brushing for the 'fun' of it or for the 'health' of it are the *real* reasons most of us pick up and use our toothbrush first thing each morning. I'm convinced many of us do this because it 'feels good' to brush our teeth. I would like to suggest that the value good oral health care habits contributes to our *overall feeling of well-being* is far more important than we, as a profession, are generally inclined to acknowledge. Over the past few years, while working with adults who are dependent on others for their personal care, I've come to the conclusion that the cleanliness and comfort that comes from mouthcare contributes to the way people feel and therefore, their quality of life. Not a profound thought, perhaps, but one worthy of our individual and collective attention.

What are we doing to help those who are dependent for care? What about the individual who has been seeing you for years for periodontal therapy who can no longer come in for



MAXINE BOROWKO,
RDH, SDT, CERT VIT Ed

an appointment or perform the daily plaque control techniques you've developed together over the years? If they can't come to us, do we need to find ways to get to them? If they can't clean their own mouth do we need to enable others to care for them on a daily basis? Does our responsibility stop at the operator door? If your answer to the last question is a resounding NO, then what can we, as a profession, do about answering the previous two?

Recognizing *there is a need* and recognizing *we have a responsibility to address that need* will go a long way to helping us find the answers. We are effective when working with clients on a one-to-one basis, we are effective when providing individual care even in addressing individual problem areas (periodontal pockets for instance), but perhaps the answers to how we can become even more effective to society as a whole can only be found if we step back and look at the big picture.

We can't afford to view the mouth and dentistry apart from the rest of the body and the health care system. Health care reform and the process of public consultation that is being utilized in most provinces to facilitate reform, provides us with a timely opportunity to act. *Now*, while policymakers are determining what is important to the health of our communities, is a prime time for us to contribute our suggestions. *Now*, while the importance of primary health care is being recognized and promoted, is an opportune time for us to advance the idea of primary oral health care. *Now* while the idea of adding 'quality to life' is gaining more popularity than the notion of adding 'quantity to life', is the perfect time to advocate for oral hygiene care for dependent people. *Now*, while you're thinking about these issues, is the ideal time for you to determine what you, as an individual, can do, and act on it.

Maxine obtained diplomas in Dental Therapy (1974) and Dental Hygiene (1984) from Wascana Institute in Regina, and a diploma in Adult Vocational Technical Education (1985) from the University of Regina. Her background includes clinical, educational and administrative positions in public health, post secondary education and private dental practice. Maxine also has experience as a dental hygienist in Long Term Care Hospitals, providing care to intermediate and extended care residents, and is currently working in Community Health providing services to the Mentally Challenged. Maxine maintains part-time employment in private dental practice. Her professional goal is to work toward the establishment of dental hygienists as recognized members of the Multi-Disciplinary Health Care Team.

Have an ethical problem? Don't know where the boundaries are?

Need help to make a decision?

CDHA Code of Ethics — Read it!

LETTER TO THE EDITOR

Dear Editor:

I have chosen to write my concerns to you, recognizing that you are the Editorial Director of *PROBE*. The last three days in Saskatoon have been extremely motivating, inspiring and thought provoking. The discussions that centred around the evolution of the profession were encouraging proactive discussions. This brings me to address a concern that I have had for some time, which is the image that the cover of *PROBE* projects.

When the theme was first initiated, I anticipated that it was "just a theme" that would prevail for a certain time period but would reach an "end" and alas, a new theme would emerge. As the theme continues to prevail on each cover, I see that my assumption was incorrect, so I feel compelled to voice my professional concerns.

In my opinion, the cover of our professional association's journal does not reflect the image that needs to be portrayed as we pursue independence and autonomy as a profession. I believe the cover projects an image of communication and support between our members which is worthy and reputable but in these changing

times, I urge you to re-consider the journal's visual projection.

In the upcoming months, changes are being sought by our profession across Canada that will have the profession being scrutinized, evaluated and challenged by other professional groups, government officials and academic committees. If we want to be recognized as a true profession with our own knowledge base, we must project that message in all possible ways which includes the cover of our journal.

I have taken the time to look at the covers of numerous other professional journals, including health professions outside of oral health. The majority carry the cover resembling scientific refereed journals. I know that the Journal of the Canadian Dental Association includes a picture of "some type" but that the majority of scientific journals do not follow this format. I don't believe that one must always follow the majority but this is not the issue. The cover of the journal should present a more scientific theme which is representative of its content, not a picturesque scene that leaves one wondering if the content will be about hiking or cycling. I recognize the saying of

"never judge a book by its cover" and perhaps many people are able to abide by this, but I fear that many people do not, so the wrong message is displayed.

I would strongly encourage you and your journal committees to revisit the discussion that occurred when the present theme was decided. Consider the message it projects in comparison to the message we should project.

Thank you for your consideration of this matter. Additionally, thanks to you and all the members who dedicate their time to the development of the association's journal.

Respectfully submitted,

Sharon Compton, RDH, BS, MA(Ed)
Asst. Professor,
Division of Dental Hygiene
University of Alberta

CDHA welcomes your comments and/or suggestions regarding issues raised in *Probe* or affecting the Dental Hygiene Profession. Send your letters to CDHA, *Probe* Managing Editor, 1018 Merivale Rd., Suite 201, Ottawa, ON K1Z 6A5.

Meet Your 1994 CDHA Board of Directors



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NEWS



The Canadian Dental Hygienists Association
 L'Association Canadienne des Hygiénistes Dentaire

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CDHA Elects New Vice-President by Acclamation

Sue MacIntosh of New Glasgow, Nova Scotia was elected CDHA Vice-President by acclamation at the CDHA Annual Session held in Saskatoon, Saskatchewan in June. Ms. MacIntosh is a graduate of Dalhousie University's Dental Hygiene Program and also holds a BA from Dalhousie. She has been a registered dental hygienist in the province of Nova Scotia since 1972 and has worked in private practices in both Metropolitan Halifax/Dartmouth and Pictou County. She is a Past President of the Nova Scotia Dental Hygienists Association (1988-90) and a member of the Discipline Committee of the Provincial Dental Board of Nova Scotia. In



addition, she served as a Director on CDHA's Practice and Regulation Council from 1990-92.

Ms. MacIntosh says she takes pride in the advancements which the dental hygiene profession has made in recent years with respect to its own self-governance and the enhanced recognition that dental hygiene is an integral part of the oral health care system. She says she believes increased public accessibility to dental hygiene services will be in the forefront of emerging professional issues and is prepared to work to meet the challenges this will present to the dental hygiene profession.

CDHA/Procter & Gamble Graduate Student Research Award Presented to Ellen Brownstone

During the Opening Greetings of CDHA's 5th Annual Professional Conference, James O'Reilly of Procter & Gamble presented Ellen Brownstone of Winnipeg, Manitoba with the 1994/95 CDHA /Procter & Gamble Graduate Student Research Award. Brownstone, who is Director of the University of Manitoba's School of Dental Hygiene, is currently enrolled in the University of Manitoba's PhD program on a part-time basis. Her doctoral thesis is examining the professionalization of dental hygiene in Canada. Brownstone is the eighth recipient of this annual award which has a monetary value of \$5,000.



Dental Hygienist Appointed as Chair, Health Sciences, College of New Caledonia

CDHA Immediate Past President, Fran Richardson Cotton, was appointed as Chair, Health Sciences for the College of New Caledonia effective June 1, 1994. She was Chair, Dental Studies since July 1991 and Acting Chair, Nursing and Social Sciences since January 1994.

As Chair, Health Sciences, Richardson Cotton will be responsible for the col-

lege's dental reception, certified dental assisting, dental hygiene, home support/resident care attendant, home support bridging and nursing diploma programs. She will also be responsible for the college's health-related continuing education opportunities.

Richardson Cotton is also a member of the Steering Committee for the Northern

Consortium for Continuing Education in Health, a group working to develop continuing education opportunities and programs for health care professionals in northern British Columbia. Members of the consortium include the College of New Caledonia, the Open Learning Agency, Prince George Regional Hospital and the University of Northern British Columbia.

CDHA President-Elect Awarded Honourary Laws Degree

Professor Margery (Marnie) Grace Elaine Forgay was presented with an Honourary Doctorate of Laws Degree from Dalhousie University in Halifax, Nova Scotia on May 27, 1994. She is the first Canadian dental hygienist to receive an Honourary Doctorate degree. She also delivered the Convocation Address to graduates of the Faculties of Dentistry and Medicine during the convocation ceremonies held at the Rebecca Cohn Auditorium of the Dalhousie Arts Centre on May 27.

The honour bestowed on Dr. Forgay this May is testimony to her dedication and commitment to the dental hygiene profession. As noted in the Citation appearing in the Convocation Programme, "She is a woman who, in the eyes of her peers, changed the perception of a dental hygienist from that of 'the girl in the office' to a highly regarded health care professional."

Born in Rosetown, Saskatchewan, the daughter of a dentist, Professor Forgay has been a teacher and a leader in the development of dental hygiene education for more than 30 years. Although she once considered an acting career (and was offered a scholarship to the Banff School of Fine Arts) to the credit of the dental hygiene profession, the acting career was not the path she chose. Marnie's decision to take the path leading her to the dental hygiene profession is one which has benefited the profession, as a whole, immensely. And for this, members of the profession throughout the country, can be grateful.

Professor Forgay received her early education in Saskatchewan, the province of her birth. She first attended the Eastman Dental Dispensary in Rochester, New York, earning her Diploma in Dental Hygiene in 1952 (Gold Medalist). She obtained a Bachelor of Arts degree from the University of Saskatchewan in 1955 and was recipient of the T. Copeland Prize for outstanding graduate in Arts and Science that year. Later she earned a Bachelor of Education degree from the University of Manitoba (1976), and completed a Masters of Arts degree at the University of British Columbia (1980). Other honours and awards include: recipient of the University of Manitoba's Saunderson Award for Excellence in Teaching (1980), University of Manitoba's Outreach Award (1980), Life Membership in the Canadian Dental Hygienists Association (1978), and the Canadian Fund for Dental Education Fellowship (1976). Furthermore, within the last ten years Marnie has been awarded five research grants totalling \$108,435.

In 1963, Marnie founded the School of Dental Hygiene at the University of Manitoba. She served as its Director from 1963 until 1976. Later, she twice served as its Acting Director. In 1985 she was appointed Director of the School of

Dental Hygiene at Dalhousie University for a five-year term. Following her term at Dalhousie, Professor Forgay returned to the University of Manitoba's School of Dental Hygiene, where she has worked until August 1, 1994, the date her resignation took effect.

Marnie was a charter member of the Canadian and the Manitoba Dental Hygienists Associations, and today is president-elect of the national association. In 1982, in Winnipeg, she was the organizer of the first-ever conference on dental hygiene research to be held world-wide, and in 1988 she served as Chair of a federal government working group on the practice of dental hygiene in Canada. Professor Forgay is an international advisor and speaker on dental hygiene research, education and practice and has delivered 39 presentations throughout North America on a wide range of professional and educational topics. She also pioneered the competency-based approach to education in the dental hygiene program at the University of Manitoba.

Marnie's professional contributions and appointments are numerous and have included: member of the CDHA Committee on National Dental Hygiene Certification, member of the Commission on Dental Accreditation of Canada, legislative representative for the Manitoba Dental Hygienists Association, Chair of CDHA's Committees on Education and Quality Assurance, Advisor to CDHA's Professional Development Council, editorial board member for the *Journal of Dental Education*, *The Canadian Dental Hygienist* and *Educational Directions*.

In 1992-93, while on study leave, Marnie was advisor to a Canadian International Development Agency (CIDA)-sponsored dental project for training primary oral health personnel in Beira, Mozambique. Among other numerous volunteer activities, Marnie has been a long time volunteer for the Kidney Foundation of Canada.

Marnie's colleagues and peers across Canada were delighted to learn of the honour bestowed upon her and share the enthusiasm an honour of this magnitude generates. And many, no doubt will agree, in this instance, it is the least one can do to recognize and acknowledge an individual who has contributed so much. (Thank you Dr. Forgay — from all of us.)

The Convocation Address delivered by Dr. Forgay to the 1994 graduates of Dalhousie University's Faculties of Dentistry and Medicine will be published in the next issue of Probe.

CDHA Honours Numerous Individuals at Annual Awards Dinner

Some of dental hygiene's most dedicated and committed 'movers and shakers' were honoured at the CDHA Annual Awards Dinner held at the University of Saskatchewan's Faculty Club on June 16, 1994. Lorraine Boomhour, CDHA's Immediate Past President, was the M.C. for the evening and began the presentations by recognizing the recent honour bestowed on dental hygiene colleague Marnie Forgay. Dr. Forgay was presented with an honorary laws degree from Dalhousie University in May.

Western Canadian dental hygienists who served as CDHA Presidents in the past were one of several groups honoured during the Awards Dinner. Among those to receive a Past President's pin were Carol Matheson Worobey (1978-79) who is currently serving as the Association's Executive Director. Matheson Worobey, on reflecting on the profession's progress since her time in office, noted that, in her opinion, CDHA hosting of its first international conference in Vancouver was a big step for the association. She also says that witnessing the growth of the profession's self-regulation from coast to coast is also an exciting occurrence and evidence of a profession truly on the move.

Diane Girardin (1979-80) remarked that the Association has come a long way since her time in office. "I remember CDHA's address was Box 22, Lasalle, Manitoba at that time and we had about 1700 members." Today the Association supports a membership of more than 6,000 and has a staff of six. Ms. Girardin also noted that in 1979 dental hygiene was considered a semi-profession which contrasts to its current recognition as an emerging profession in its own right.

Dianne Gallagher (1985-86) apologized for her rumpled appearance as she headed to the podium to accept her past president's pin. It was, she said, due to the fact that she had "just given birth to an elephant". And, in many ways, she had. Prior to the Awards Dinner, Gallagher had organized and chaired the inaugural meeting of the National Dental Hygiene Certification Board (NDHCB) — and that meeting, did indeed, constitute an enormous birth. A birth that has been labour intensive for Dianne, since she has steered the process from its conception to birth.

Marge Bailey, who served as CDHA President from 1980-81, was unable to attend the dinner to accept her past president's pin.

Following recognition of CDHA past presidents from Western Canada, Practice and Regulation Council Chair, Diane McCambly, called upon representatives of three dental hygiene licensing bodies. The very existence of these licensing bodies testifies to the profession's remarkable progress as it moves towards the goal of self-determination and 100% self-regulation. Currently, 90% of dental hygienists in Canada are self-regulated and CDHA presented plaques honouring the efforts of those instrumental in helping the profession attain this remarkable achievement to date. Plaques were presented to Brenda Walker, representing the Alberta Dental Hygienists Association, France McKenzie representing the Corporation Professionnelle des Hygienistes Dentaires du Quebec and Lynda McKeown Mickelson representing the College of Dental Hygienists of Ontario.

Certificates of Appreciation were presented to Joanne Clovis of Halifax, NS and

Dianne Gallagher of Victoria, BC for their contributions to the development of CDHA's Scientific Journal, *Probe*. Both Dianne and Joanne were former members of the publication's Editorial Board. CDHA President-Elect, Maxine Borowko who presented the certificates of appreciation noted that it is individuals like these who provide the "mutual support and positive energy" the profession needs if it is to continue to meet the challenges of the future. "We need to celebrate our differences and continue to focus on how we can affect others and ourselves," she remarked.

The Chair of CDHA's Professional Development Council, Marg Wilson, took pride in presenting Nancy Prowse of Dartmouth, Nova Scotia with a Distinguished Service Award. Ms. Prowse was honoured in recognition of her contributions to the development of the CDHA Code of Ethics, a critical document released in June 1992 that defines and clarifies the ethical principles of the profession, identifies the basic moral commitments of dental hygienists and serves as a source for education, and reflection and a basis for self-evaluation and peer review.

One final award was presented during the dinner, to Sheryl Feller, a familiar name to many dental hygienists actively involved with the national association. Ms. Feller was awarded the highest honour of Life Membership in CDHA in recognition of her contributions and dedication to the dental hygiene profession.

It was a memorable evening for many in attendance, one charged with positive energy and enthusiasm and one which, in many ways, reflected the energy and excitement the profession generates as it forges ahead into previously uncharted waters.



In January 1994, CDHA welcomed three new members to the CDHA Board. Pictured below is President-Elect Marnie Forgay welcoming: (l-r) Judy Parker of Victoria, BC a member of the Health Promotion Council; Judy Clarke of Edmonton, AB, a member of

CDHA Welcomes New Board Members

the Practice & Regulation Council and Wanda Staples of Ottawa, ON, a member of the Health Promotion Council.

In June 1994, another two new individuals were welcomed to the CDHA Board.



(left) Kathleen Adams of Welland, ON, a member of the Practice & Regulation Council, (centre) CDHA Immediate Past President, Fran Richardson Cotton, and (right) Heather Tommy of Manotick, ON, a member of the Health Promotion Council.

New Safety Code for Dental X-Ray Equipment Released

A new publication, essential for dental professionals utilizing x-ray equipment, is now available from Canada Communication Group Publishing. **Radiation Protection in Dentistry: Recommended Safety Procedures for the Use of Dental X-Ray Equipment — Safety Code-30** contains specific recommendations for minimizing radiation exposure to both clients and staff.

Safety Code-30, which replaces *Safety Code-22 (1981)*, is concerned with the protection of individuals who may be exposed to radiation emitted by x-ray equipment used in the practice of dental diagnostic radiology. Prepared and compiled by Christian Lavoie, P.Eng., of the Health Protection Branch at Health Canada, this 88-page edition emphasizes quality control monitoring of x-ray equipment and image processing.

In addition to highlighting the responsibilities of the owner, dentists and operators, *Safety Code-30* specifies minimum regulatory standards of design, construction and performance for x-ray equipment as outlined under the *Radiation Emitting Act*. The publication also provides guidance on implementing and operating a Quality Assurance program and offers information for determining adequacy of shielding in absorbing primary and stray radiation.

Appendices provide quick access to a variety of information, including:

- recommended dose limits of x-ray radiation to operators and others;
- shielding guides for dental facilities;
- provincial/territorial radiation safety agencies of dental facilities;
- regulations for radiation-emitting devices for dental x-ray equipment with an extra-oral source (based on the 1993 amendments).

Copies of **Radiation Protection in Dentistry: Recommended Safety Procedures for the Use of Dental X-Ray Equipment — Safety Code-30** are available through Communication Group — Publishing (CCG-P), Ottawa, Canada K1A 0S9 or call (819) 956-4800.

CDAA To Honour Members in Vancouver

The Canadian Dental Assistants Association (CDAA) will grant Honorary Life Membership in CDAA to the following individuals in recognition of their meritorious service and outstanding contribution to the Association: Susan Anholt of Kenaston, SK, Marlane Paquin of Vancouver, BC, Diane Pike of Brockville, ON and Elizabeth Purchase of St John's, NF.

In addition, the following CDAA members will be presented with a CDAA 25-Year Pin at its Annual General Meeting being held on October 1, 1994 in Vancouver, BC: Merl

Cory of Vancouver, BC, Gayle Cowper of Richmond, BC, Linda Olsen of Williams Lake, BC, Marlane Paquin of Vancouver, BC, Elizabeth Purchase of St. John's, NF, Letitia Quail of Penticton, BC and Maureen Symmes of Edmonton, AB.

Alberta Dental Hygienists Association Finds A New Home

The Alberta Dental Hygienists Association has a new address. As of May 25, 1994 the Association's headquarters will be at 222, 8657 - 51 Avenue, Edmonton, AB T6E 6A8. Executive Director, Brenda Walker, says she looks forward to welcoming ADHA members to the new location. Walker remarked that the plaque presented to the Association by CDHA at the CDHA Annual Awards Dinner held in June in Saskatoon (in conjunction with CDHA's 5th Annual Professional Conference) will be the first item to adorn the new walls. The plaque was presented in recognition of ADHA's contributions to the self-regulation of the profession.

ERRATA

In our News from Schools feature that appeared in *Probe* Vol. 28 No. 4, we incorrectly identified Jo Gardner as an instructor in the BScD Program at the University of British Columbia. She is in fact a student in the program. Our apologies for any embarrassment or inconvenience this error may have caused.



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CDHA Extends Thanks to Dental Industry for Its Continued Support

CDHA's Corporate Relations Officer, Joan Degan, wishes to extend a hearty thank you to the many dental industry representatives who contributed to the success of the Association's 5th Annual Professional Conference held in Saskatoon in June. The success of this annual event is, to a large extent, due to the continued support of our exhibitors and sponsors:

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Wrigley Canada

We hope to see you at CDHA's 6th Annual Professional Conference being held in Halifax, Nova Scotia, June 16-18, 1995. **Set Sail for Halifax!**

CDHA Extends Hearty Thank You to SDHA and 'Joan'

CDHA wishes to take this opportunity to thank its Corporate Relations Officer, Joan Degan, for her tireless efforts in relation to the recent CDHA Annual Professional Conference held in Saskatoon. Joan spent countless hours rounding up corporate sponsorship for this event and its success is very much a reflection of her hard work. A big thank you Joan — for all your help!

Although Joan played a key role in the planning and coordinating of CDHA's 5th Annual Conference, she did not work alone. CDHA would like to take this opportunity to express its appreciation to *all* members of the Local Organizing Committee led by Maureen Bowerman and Barbara Long, who devoted many hours and much effort to ensure the success of the event. Our thanks to: Maureen Bowerman, Barbara Long, Caroline Yelland, Shelley Ruiters, Nancy Fritz, Wendy Saganski, Mary Anne Wailing, Denise Nelson, Darcy Tkatchuk, Tracy Thompson-Oliver, Charlane Holowachuk, Jacqueline McLary, Nancy Bateson, Diane Moore, Christine Gordon, Darlene Armstrong and Noel Selinger for a job well done.

Sue Who?

CDHA Members may be wondering who the new voice at the end of the line belongs to...if it's Sue, it is Sue Turcotte, CDHA's newest Central Office staff addition. Sue, who worked on a part-time basis with CDHA since September 1993, became a permanent staff member in May 1994. As Member Services Assistant she maintains the CDHA membership database and assists Sandra Vanwart, the association's Membership Coordinator, with all responsibilities related to membership. Sue has been a resident of Nepean since emigrating from England over twenty years ago. Before joining CDHA she gained experience in the banking, accounting and payroll fields through various companies. In England she worked as a post-natal nurse and as a surrogate parent for children residing in group homes.

In Vol. 28 No. 4 July/August we neglected to provide a photo credit with the photo accompanying the news article entitled "Oral Health Day Celebrations". Our thanks to John Morrow, staff photographer with the *Abbotsford/Matsqui News*.

Dental Hygienists & Dental Assistants

Come Join Your United States Colleagues For A Seminar, An Exchange of Ideas, And Friendship At The Clinical Congress — Halifax, Nova Scotia On Saturday, November 5, 1994 from 9:00 AM - 12:00 PM At The Holiday Inn, Halifax.

AGENDA

Diabetes Mellitus — Management in the Dental Office

- I. Pathology And Diagnosis
- II. Treatment Of Diabetes Mellitus
- III. Chronic Complication of Diabetes Mellitus

The Adrenal Gland — Management in the Dental Office

- I. Structure And Function
- II. Glucocorticoid Deficiency
- III. Glucocorticoid Excess

Clinician: **Martin J. Dunn, D.M.D.**

* Diplomate American Board Of Oral And Maxillofacial Surgery * Professor Head And Neck Anatomy Forsyth School Of Dental Hygiene
* Author Of Several Books For Dental Auxiliaries * Lecturer For Thirty-One Years Throughout The World To Dental Auxiliaries And Dentists
* Private Practice Oral And Maxillofacial Surgery * Clinician On Many Occasions To Canadian Dental Hygienists

Tuition for Saturday, November 5, 1994 — 9:00 AM - 12:00 PM will be \$35.00 US. Registration Deadline will be **October 25, 1994**.
Please make check payable to *Aisling International* and mail to:

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Questions and concerns may be addressed by calling (617) 696-3350 and FAX (617) 696-3601. Early registration is suggested as enrollment will be limited. Your tuition will be refunded in full if you wish to withdraw from the course any time prior to 5 days before the course is given. Information is available about participating in the social events of the weekend.



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1993 NORTH AMERICAN RESEARCH CONFERENCE

An Exploration into the Future

Niagara Falls, ON
October 15-17, 1993

CODE	PRESENTATIONS	QUANTITY	TOTAL
Saturday, October 16, 1993			
1A	Theory Development Workshop — Fawcett, Dr. Jacqueline		
1B			
Sunday, October 17, 1993			
2A	Qualitative Research — Grant, Dr. Karen		
2B	Common Flaws in Research — Bowen, Denise		
3A	Mini-Sessions		
3B	Lasers — Ling, Patricia Saliva Research — Dawes, Colin Micro-Diagnosis — Goulding, Marilyn Health Policy, Demographics and Economics — Clovis, Joanne		



CANADIAN DENTAL HYGIENISTS ASSOCIATION

5th Annual Professional Conference

June 17-19, 1994 • Saskatoon, Saskatchewan

SHARPEN YOUR PROFESSIONAL EDGE

CODE	PRESENTATIONS	QUANTITY	TOTAL
Friday, June 17			
1A	"Saving Medicare — The Power and The Glory" — Rachlis, Dr. Michael		
1B			
2	"New Clients, New Settings, New Questions" — Borowko, Maxine Ethical Dilemmas to Consider When Meeting the Needs of Special Clients, Groups — Guest, Lynn		
3	"Applied Ethics in Dental Hygiene Practice: Voicing our Values" — Chiodo, Dr. Gary		
4	"Dental Hygiene and Health Care: Coming to Terms with the Ethical and Moral Dilemmas" — Cotter, Brent		
Saturday, June 18			
5A	"Excellence in Root Instrumentation: Where are We Today?" — Otero, Dr. Francisco		
5B			
6A	Free Papers		
6B	Changes in the Social Organization of Health Care Delivery — McKeown Mickelson, Linda Patient Compliance for Implant Maintenance — Bapoo-Mohamed, Karima Continuing Education: An Ethical Concern — Lautar, Charla Examining Attitudes Towards AIDS Patients in an Attempt to Understand Behaviour: A Literature Review — Keenan, Louanne		
Sunday, June 19			
7	Panel I — Can Ethics Be Learned? Moderator: Marnie Forgay, Dip DH, BEd, MA, PhD Panelists: Nancy Prowse, Dip DH, BEd, MA Gary Chiodo, DMD Sharon Compton, RDH, BA, MA(Ed) Nancy Keselyak, RDH, MA		
8	Panel II — The Ethics of Access to Care Moderator: Jenny Thomas, RDH, BA, MEd Panelists: Rick Holocky, Benefits Consultant, Canadian Actuarial Norm Lemke, Director of Human Resources for the Renfrew County and District Health Unit		
9	"The California Vision" or How a Peace Time Maneuver Turned into a War — Segal, Toby		
10	Panel III — New Practice Arrangements Moderator: Sheryl Feller, RDH, MBA, CMC Panelists: Dianne Landry, RDH, MDN, BA, BV/TEd, Myrna Frizell, RDH, Lynda McKeown Mickelson, RDH		

National Certification: A Vital Component of Quality Assurance

By:

*Dianne Gallagher, Dip DH, BGS, MEd
Margery Forgay, Dip DH, BEd, MA*



**MARGERY FORGAY,
DIP DH, BEd, MA**

It's official, the National Dental Hygiene Certification Board (NDHCB) held its inaugural meeting in Saskatoon, Saskatchewan in June, in conjunction with CDHA's 5th Annual Professional Conference. We hope this article will help you understand its role in the 'big' picture.



**DIANNE GALLAGHER,
DIP DH, BGS, MEd**

In 1982, in response to a priority concern of members, the CDHA began to investigate a national certification process to enhance portability (the ability of dental hygienists to become licensed in all Canadian jurisdictions) through a nationally recognized credential. By 1984 the CDHA Board of Directors had endorsed the concept of having a single national standard for entry to practice and began investigation of a system which could provide that standard and enhance quality assurance.

Many professions, among them pharmacy, medicine, architecture, law, nursing, physiotherapy, occupational therapy, medical laboratory technology, and dentistry espouse certification. The features of certification that are of special importance to dental hygiene are:

- providing a mechanism reflecting a national standard for assessment of candidates for entry and/or re-entry into practice, and
- facilitating portability of licensure from one province to another.

Quality assurance is of major concern to all health care professions, and national certification is one element of the overall process of quality assurance. There are three main focuses of quality assurance processes employed by various professions:

- practice and continuing competence, and
- entry into the profession
- education

MECHANISMS OF QUALITY ASSURANCE

PRACTICE AND CONTINUING COMPETENCE

- practice standards
- code of ethics
- management statement
- mandatory continuing education
- peer evaluation
- mandatory testing

ENTRY INTO PRACTICE

- licensure
- registration
- provincial board examination
- national certification

EDUCATION

- accreditation
- curriculum guidelines
- theories and models of care
- standards (educational/practice)

W. HALOWSKI 1993¹

Education

- a) *Standards:* Some standards for dental hygiene education exist, but are not very explicit. A profile of clinical competencies for dental hygiene was established in 1987 by the Commission on Dental Accreditation of Canada, but the competencies were loosely defined and were never further developed to include related knowledge, nor has the profile ever been updated. A joint initiative of CDHA and the Allied Dental Educators' section of the Association of Canadian Faculties of Dentistry is presently under way to develop new educational standards that may be used for both education and accreditation purposes.
- b) *Accreditation:* Accreditation of dental hygiene programs in Canada is the responsibility of the Commission on Dental Accreditation of Canada. Guidelines for accreditation of dental hygiene programs, including the evaluation of the outcomes of clinical care, assist in the development and improvement of dental hygiene education.² Recent initiatives, including the development of education standards and their intended incorporation into the guidelines, illustrate ongoing efforts to strengthen the accreditation process.
- c) *Curriculum Guidelines:* The American Association of Dental Schools has produced and periodically updates curriculum guidelines for dental hygiene education. These guidelines are discipline-based, and are written and content validated by dental hygiene educators. In the absence of a Canadian document AADS guidelines are commonly used by Canadian schools.

Another recent document which has quickly become influential in almost all curricula for health care providers is "Healthy America Practitioners for 2005".³ In it the Pew Health Professions Commission identifies the characteristics of health care professionals "with expanded abilities and new attitudes to meet society's evolving health care needs". It proposes that health care practitioners in 2005 will:

- care for the community's health
- expand access to effective care
- provide contemporary clinical care
- emphasize primary care
- participate in coordinated care
- ensure cost-effective and appropriate care
- practice prevention
- involve patients and families in the decision making process
- promote healthy life styles
- assess and use technology appropriately
- improve the health care system
- manage information
- understand the role of the physical environment
- provide counselling on ethical issues
- accommodate expanded accountability
- participate in racially and culturally diverse society
- continue to learn

The above characteristics appropriately describe dental hygienists and will be reflected in the education and practice standards that are presently under development/revision in Canada. These in turn will shape and guide the study and practice of the profession of dental hygiene in the future.

- d) *Theories and Models:* Leaders in the profession believe that it is essential to the advancement of dental hygiene that it be recognized as a discipline distinct from any other. Disciplines are distinguished from one another by the major concepts they study through

research. A discipline's statements and its paradigm concepts make up the framework for theory development and ensuing research.⁴ In Canada, as elsewhere, there is an increasing amount of dental hygiene research, leading to the development and testing of dental hygiene theories and models of practice.

Entry into the Profession

- a) *National Certification:* As it relates to health professions, certification is an entry to the profession mechanism which assures that candidates have met specified standards for beginning practice. In Canada, many professions as mentioned earlier, have mechanisms for national certification. Usually they consist of written or clinical examinations or both. Although national certification processes presently exist for dentistry and dental assisting, **national certification for dental hygiene is only now becoming a reality.**

The objectives of national certification for dental hygienists have been specified as follows:

1. To further the public interest by providing a mechanism that reflects a national standard for the assessment of candidates for entry into the practice of dental hygiene, and
2. To encourage and facilitate portability of licensure from one dental hygiene licensing jurisdiction to another.

The National Dental Hygiene Certification Board which had its inaugural meeting in June 1994, is composed of members appointed by each participating dental hygiene regulatory body, CDHA, the Association of Canadian Faculties of Dentistry, the Commission on Dental Accreditation, and the public. Once national certification is fully implemented, all those wishing to enter dental hygiene practice in Canada will take the National Certification (written) Examination, currently being developed. The examination will be given in several centers across Canada twice a year. The development of a clinical component of the examination is intended as a future initiative.

Dental Hygienists presently licensed and in good standing with the regulatory body in any jurisdiction in Canada will be permitted for a limited period of time to obtain national certification through a process known as 'grandparenting'. This involves application and payment of a specified fee. Grandparenting has been adopted by many professions as a reasonable way of recognizing professionals who are currently licensed and performing at levels acceptable to the profession at the time when national standards are introduced. Proceeds from the grandparenting initiatives are used to develop a mechanism for future use. An alternative also used by some professions for a designated initial time period is a **licence levy**. Through a levy, each licensed registrant shares equally in the development costs for the certification process. Some dental hygiene licensing authorities will choose this way of recognizing the new process. Once the allowed time for 'grandparenting' and licence levies has elapsed, the only mechanism for obtaining national certification will be writing the examination.

- b) *Provincial Board Examinations:* These have been in existence in some provinces for many years, but not without several problems. For example, examinations have varied in content, difficulty and process. Some have been questioned with regard to validity and reliability. A major concern has been the lack of reciprocity from province to province and the resulting restriction on mobility. Dental hygienists have complained that provincial licensing

examinations have unduly discriminated against those who move from province to province because those who continue to live and work in the same jurisdiction are not required to re-qualify. The national certification process will address many of the problems mentioned above.

- c) *Registration and Licensure*: Dental Hygienists are now registered in all provinces in Canada. To be registered gives the dental hygienists the right to the title and to practice dental hygiene according to the provincial regulations. Most provinces require dental hygienists to pay an annual license fee. The licensing jurisdiction sets the requirements for licensure and the scope of practice. Across the provinces, these requirements vary: restorative skills, administration of local anaesthetic, and orthodontic procedures are allowed or required in some provinces but not in others. One of the requirements for any dental hygienist wishing to register in a province participating in national certification will be possession of a national certificate.

Practice and Continuing Competence

- a) *Practice Standards*: These define the structures, processes and outcomes necessary for the delivery of quality dental hygiene care. In 1988, the federal government sponsored Working Group on the Practice of Dental Hygiene published clinical practice standards for Canadian Dental Hygienists.⁵ They were endorsed the same year by CDHA, and CDHA has promoted their integration into practice through the development of continuing education materials and conducting workshops which encourage self-assessment by practicing dental hygienists. The practice standards are undergoing revision and expansion to update standards for clinical practice and include dental hygiene practice in community health, research, and administration.

- b) *Code Of Ethics*: Revised in 1992, the CDHA Code of Ethics sets down values and describes professional conduct of dental hygienists.⁶ Values express broad ideals, and professional conduct standards set out moral obligations inherent in those values. The Code of Ethics also functions to educate the public about the aspirations, ethical values, and standards of the profession. It also outlines the moral commitments of practitioners and guides them in the resolution of ethical dilemmas. Finally, the Code of Ethics provides standards for self-evaluation and peer review.

- c) *Mandatory Continuing Education*: All professions encourage members to update their knowledge continuously. The practice of requiring continuing education in order to maintain a license to practice is becoming more common. Three provinces now require specified continuing education credits within a given period of time. Failure to comply may result in loss of the right to practise.

- d) *Peer Evaluation*: Some professions utilize peer review to assist in ensuring continuing competence. In Quebec, standardized practice inspections are carried out in an effort to monitor and uphold standards of practice.

- e) *Mandatory Testing*: This practice does not currently apply as a measure of continuing competence in dental hygiene. A few professions use it to diagnose knowledge deficits, followed by specific continuing education requirements and peer review.

National Certification provides a valuable addition to the six processes in place or being developed to assure quality dental hygiene care in Canada. The CDHA has been working toward implementation of national certification for several years. This work has now reached fruition, and in the very near future, national certification will be available to all dental hygienists in Canada: those who are presently licensed and in good standing through 'grandparenting' or licence levies and for those entering practice, through the National Dental Hygiene Certification Examination.

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4. Deck, S., Nielsen-Thompson, N., and Walsh, M., *The A.D.H.A. Framework for theory Development: A White Paper Requested by the 1992 House of Delegates*, Journal of Dental Hygiene, Vol 67, (4), 1993.
5. *Clinical Practice Standards for Dental Hygienists in Canada*, Report of the Working Group on the Practice of Dental Hygiene @ Minister of Supply and Services Canada 1988.
6. *Code of Ethics*, Canadian Dental Hygienists Association 1992.

Next issue we will feature an article providing more details and an update on the NDHCB activities. Watch for it!

Dianne Gallagher is a graduate of the University of Manitoba's School of Dental Hygiene and received a Masters of Education from the University of Regina in 1992. She has been working in education since 1975. She is a CDHA Life Member and Past President. She is also the current Chair of the National Dental Hygiene Certification Board (NDHCB).

Margery Forgay has been a teacher and leader in the development of dental hygiene education for more than thirty years. She earned a Diploma in Dental Hygiene from the Eastman Dental Dispensary in Rochester, New York, a Bachelor of Arts degree from the University of Saskatchewan (1955), a Bachelor Education degree from the University of Manitoba (1976) and a Masters of Arts degree from the University of British Columbia (1980). In May 1994 she was presented with an Honourary Doctorate of Laws Degree from Dalhousie University in Halifax, Nova Scotia. She is currently CDHA President-Elect, a member of the National Dental Hygiene Certification Board and a member of the Commission on Dental Accreditation of Canada.

Dental Hygienists Are Not Immune: Wife Assault as a Workplace Issue in Dental Practice

By:

Joan Gillespie, MSW, CSW and Donna Denham, MSW, CSW

Policy Associates, Family Violence Program, Canadian Council on Social Development

Wife abuse is an important issue for dental hygienists and yet it's an issue which, until very recently, has had little discussion. We hope, through this article, to increase your understanding of wife abuse and to outline how, as dental hygienists, you can play an important role:

- in supporting abused women;
- in creating work environments which clearly give the message that any form of violence is not to be tolerated.

For years common myths have supported the idea that wife assault was not a major problem, that it happened only to a few women and that it was a private family matter. Somehow women who were being abused by their partners were expected to put it behind them when they came to work and just "get on with the job". For years women have done just that but the costs have been high, both in their own continued suffering and in workplace productivity.

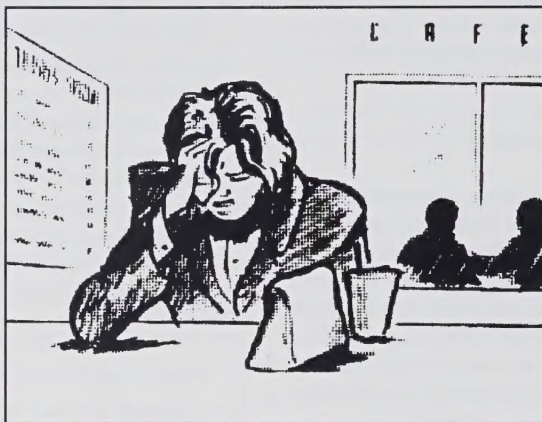
Now, with increased public awareness of the pervasiveness of violence against women and its devastating psychological and physical impact, it is time to look within our organizations to see what we can do to support the abused women who are our colleagues, our clients, ourselves. Whether we work in the public or private sector, in small practices or large institutions, the challenge for all of us is to find ways to ensure that we are part of the solution to the problem of violence.

The recent **Violence Against Women survey by Statistics Canada** (November 1993) identified some shocking facts:

- almost one-half of the 12,300 women surveyed reported violence by men known to them since the age of 16;
- one quarter of all women in Canada have experienced violence at the hands of a current or past marital partner (includes common-law unions);
- more than one-in-ten women who reported violence in a current marriage have at some point felt their life was in danger.

These statistics verify that violence against women by their partners is a serious issue, that it is widespread, and that it could happen to any of us.

An example: The number of licensed dental hygienists in Canada in 1991 was 9,655. Since the membership is primarily female, we can assume, based on the Statistics Canada figures, that over 2400



dental hygienists have experienced violence by a partner at some point in their lives. Many of these women will still be living in violent relationships.

How does being in an abusive relationship affect women in their workplace and what kind of support do they want? To find some answers to these questions we interviewed twenty-one women from across Canada who had been abused. Based on their experiences and insights the practical guide *Wife Abuse — A Workplace Issue: A Guide For Change* was developed.

Much of the material in this article is based on information from these women, and from the many other women in workplaces across the country, who have spoken to us since.

For all of us, regardless of our type of work, there are some fundamental questions which we must answer in order to raise our own awareness:

1. Why do some men abuse the women they love?
2. Why do women stay?
3. What is the effect on children of witnessing mom being abused?
4. How does wife abuse affect women in their workplaces?

1. Why do some men abuse the women they love?

Abuse is not about love, it is about power and control. There are a variety of explanations given to explain abusive behavior including:

- They believe they have the right to control their partner through threats and violence.
- They hold rigid expectations of male/female or adult/child roles.
- They are often extremely jealous and believe they must guard their partner in order not to lose her to another man.
- They may have been battered or witnessed violence as a child.
- They have not learned how to express their feelings other than through aggressive acts. Men are taught to hide feelings except anger and rage. They learn to expect women to take care of their emotional needs.
- They blame others for their own problems.

None of these reasons are acceptable excuses for abuse. As adults we are all responsible for our own behavior. **There is never an excuse for violence.**

2. Why do women stay?

We often hear people say, "Why does she put up with the abuse? I never would. If he ever laid a hand on me I would be out the door so fast..." Unfortunately the solutions for abusive relationships are not so simple, and anyone who has experienced one knows this.

Women stay because:

- They fear for the physical safety of themselves and their children.
- They fear that their professional credibility will be damaged if it becomes known that they are being abused.
- It is an economic necessity. The cost of housing and childcare is prohibitive.
- They are isolated from family, friends and support systems. They may not know what help is available.
- They love their partner. They don't want to end the relationship, they just want the abuse to end. They don't want to do anything which might hurt him (e.g. having him arrested).
- They believe that it is their responsibility to make the relationship work and they blame themselves when it doesn't. "I can change him if I work hard enough at it".
- They believe children need both parents.
- Their past childhood experiences which contribute to their thinking that abuse is a "normal" part of family life.
- Their religious/cultural beliefs dictate that it is morally wrong to separate or divorce.
- There are legal roadblocks that prevent women from engaging in lengthy, expensive court battles.
- They fear losing custody of the children.

For dental hygienists who are in abusive relationships there is the added pressure which comes from the belief that as health professionals they should be able to handle their own problems without the help and support of others.

3. What is the impact on children living in families where Dad abuses Mom?

The impact on children who witness wife abuse is enormous. Here are just a few effects:

- Children who witness abuse exhibit the same symptoms as children who are direct victims of child abuse.
- Children who have grown up as witnesses or victims of abuse are ten times more likely to live in a violent relationship when they are adults.
- They suffer social, emotional and psychological consequences: low self esteem, lack of self confidence, feelings of guilt and responsibility for their mother's suffering and their father's anger, poor peer relationships.
- They exhibit behavioral difficulties and conflict with other children.
- They often exhibit poor academic performance and difficulty in concentrating.
- They develop attitudes and learn behaviors which may perpetuate the cycle of violence in future relationships.

4. How does wife abuse affect women in the workplace?

As in any discussion of wife abuse, there is no simple answer to this question. For some women the workplace is their refuge, and the secrecy with which they surround their abuse is essential to maintaining their sense of worth. They do not look for, or want, their workplace to get involved in their private lives.

For other women, the situation is different. As well as having to survive the abuse in their private lives, they have the added burden of trying to function at work under enormous stress and fear. Their

ability to do their job may be hampered by frequent absences, pre-occupation with domestic problems, threatening personal phone calls or a limited attention span. Fear of losing their job, fear of being blamed and judged by bosses and co-workers, and fear of their abusive partner turning up at the work site, are just a few of the issues they face regularly.

An abused woman working as a dental hygienist in a small private practice faces particular barriers. If she does choose to talk about the violence in her life, she may initially get support from co-workers; over time, however, the support may dissipate if the abuse is not easily resolved (which it rarely is), or if her personal needs for support place more and more demands on others in the practice. Understanding of the dynamics of abusive relationships and information on community resources is essential for the dental team to effectively support their colleague.

Whether or not the women we interviewed chose to talk at work about the abuse in their lives, they all agreed that the workplace had an important role to play in providing a supportive environment and in offering them information on the resources available, both at work and in the community.

All abused women reveal that once the cycle of abuse is in place, abuse or the 'threat of abuse' is ever present in their lives. They live their lives "on edge". They often talk about planning actions and decisions, including many that affect their work life, around their abusive partner's demands.

In some cases there are women who have partners who use the workplace in overt ways to extend their control over their partners. More common examples of ways men do this include:

- making harassing phonecalls to the workplace;
- threatening to go to the workplace to kill the woman;
- sending anonymous letters, faxes to bosses to make unfounded accusations about the woman or her relationship with the boss;
- threatening to hurt the children while the woman is at work.

If abusive partners place a high priority on the woman's ability to contribute financially to the home then the men tend not to participate in activities that would put the woman's job at risk.

Whether men use the workplace directly to exert control over their wives and girlfriends or specifically avoid using the workplace, women have said that the abuse by their partners eventually affects their ability to do their jobs. As abuse escalates or the pattern of control and fear drags over longer periods of time (years in some cases) the spillover into the workplace becomes more pronounced.

Women who are abused by their partner at home may face a double jeopardy if they are in a workplace with an abusive boss. This is a scenario which may be a reality for some dental hygienists who are working for dentists who are abusive.

The following examples clearly illustrate how the abuse in women's lives directly impacts on their work.

Attendance:

- "I didn't miss much work unless my injuries were obvious."
- "I asked for as much overtime as I could get so I didn't have to go home. I worked more than anybody else."
- "I was always owing time for sick leave."

Concentration and Fatigue

- "I believe I was functioning at about 50%."
- "I know I went to work every day but for the last six months I couldn't tell you what I did."
- "I was not fit to be working. I went to work on no sleep many times because he would not let me sleep."

Emotional Stability on the job:

- "I would break into tears. My co-workers often thought it was something they said or did. I could never tell them the truth."
- "I always believed that I was leading a double life. This created incredible stress for me."

Other impacts:

- "I missed a couple of promotions because my husband knew I had interviews and marked me so I couldn't go."
- "I couldn't go to any staff social events."
- "It eventually destroyed my career. We'd argue all night. The stress led to physical symptoms (nausea, diarrhea). In the office I was scatterbrained. I had several promotions and saw it all go down the tube in the last year."

Although women give examples indicating some rather significant deterioration in their work most report that their poor performance was seldom addressed by superiors. If a problem was identified, it was done by co-workers through "grapevine gossip" and was often labelled a "personality problem" or a "problem at home". For many women the stress of abuse eventually leads to job loss.

What can be done to make workplaces supportive to abused women?

Asking questions about abuse and providing information on community resources on a routine basis has been one of the positive steps taken by many health professionals. Women survivors of abuse have told us repeatedly that they are often too ashamed or too scared to mention the abuse to anyone. Women who strongly denied the abuse, when originally asked, said that the fact they were asked was a turning point for them when they knew that the person asking the questions was:

- concerned;
- open to talking about wife abuse;
- a source of helpful information, if and when, she decided to act.

Dental hygienists who learn to ask questions designed to provide an opportunity for women to safely disclose their abuse are in a good position to be of assistance to women survivors whether they be fellow workers or clients.

One of the barriers for many of us in asking the questions about abuse is that we are afraid we then have to "solve the problem". This is not true. There is no single or simple solution to wife abuse and each abused woman's plan of action will be unique to her. The following guidelines may assist you in asking about abuse in a caring and supportive manner.

What You Can Do To Help An Abused Woman Co-worker - Client - Friend

- **Believe her.**
- **Listen** and let her talk about her feelings.
- **Give clear messages:**
 - **violence is never okay or justifiable,**

- the safety of the woman and her children is always the most important issue,
- wife assault is a crime,
- she does not *cause* the abuse,
- she is not to blame for her partner's behavior,
- she cannot change her partner's behavior,
- apologies and promises will not end the violence,
- she is not alone,
- she is not crazy,
- abuse is not loss of control, it is a way of controlling another person.
- Talk with her about what she can do to plan for her and her children's safety. Allow her to *make her own decisions*.
- Help her identify the good things about herself and her children.
- Know the key resources in the community and how to contact them.
- Get her a copy of a *community resource list*.
- Respect her confidentiality.

An abused woman needs our support and encouragement in order to make choices that are right for her. However, there are some forms of advice that are not useful, and even dangerous, for her to hear:

Don't

- Don't tell her what to do, when to leave, or when not to leave.
- Don't tell her to go back to the situation and try a little harder.
- Don't rescue her by trying to find quick solutions.
- Don't suggest you try and talk to her husband to try and straighten things out.
- Don't tell her she should stay for the sake of the children.

Although the number of women speaking out about wife abuse has proliferated in the past few years it is important to realize that it continues to be the exception for women to disclose abuse by partners on an individual basis. The workplace is considered, by many, to be the most dangerous place to disclose because of the fear of judgment and loss of job. Thus effective individual intervention is not enough.

A comprehensive workplace strategy for dental hygienists to consider includes:

1. Conduct workplace awareness sessions.

- Develop sessions that make everyone link the issue to their own lives. This is not an us/them issue. Whether we can identify them or not, the reality is that all of us know women who have been, or are being abused.
- Look at all forms of abuse, not just physical. Emphasize that control is often maintained through emotional and psychological abuse.
- Use a variety of avenues for keeping the issue up front: posters on wife abuse prevention, community resource pamphlets, 'lunch and learn' sessions, team meeting discussions, journal articles which make links to the dental practice.
- Make family violence one of the issues that always gets identified in stress workshops.

2. Help dental hygienists to be safe in the work places.

If someone you work with is being abused by her partner, help her to create safety plans for use in the workplace e.g. screening calls, limiting access of visitors, not releasing information about a woman's activities to her husband, boyfriend, or ex-husband. It is important to know that abuse does not end with separation, often it escalates. The need for safety plans often becomes even more important once the woman has left her abusive partner.

3. Make information on resources accessible to both staff and patients.

- Identify family violence as one of the problems for which help and referral is available.
- Find creative ways to have community resource phone numbers available to both dental practice staff and patients without them having to identify themselves.
- Order a free subscription to *Vis a Vis*, the national newsletter on family violence, for the staff room and the waiting room.
- Provide choices of counsellors and information on resources outside of work. (Some women will never choose to use workplace resources even if they are available.)
- Look for resources that are culturally appropriate and in different languages.

4. Develop policies that create supportive work environments.

- Time off, flexible hours, altered shifts, leave of absences are often essential supports for abused women. Depending on the size of the organization in which the dental hygienist works, these arrangements may be made informally or written into policy and procedures.
- State, in work agreements, that attending appointments related to escaping wife abuse situations is an appropriate use of the days designated as family-related leave days.
- Train all dental practice staff on how to ask appropriate questions related to wife abuse and provide information on resources to them. (Many communities in Canada have a pamphlet listing community resources for abused women. For information contact your local transition house for abused women.)

A Community Role for Dental Hygienists In The Work To End Violence

Wife abuse is one part of the larger issue of violence in families and in our society. Solutions to violence call for large-scale social change. Dental hygienists can play an important role in this change process.

For example, involvement with a local women's shelter through:

- fundraising,
 - donation,
 - crisis line or shelter volunteer work,
 - board membership,
 - participation in activities of Family Violence Prevention month,
- all provide opportunities for dental hygienists to support community action, gain personal satisfaction and enhance the professional image of the dental hygienist.

Building an informed and supportive dental practice workplace through awareness raising strategies and by advocating for supportive policies is difficult but necessary. Clearly dental hygienists cannot do it alone. You need the support of everyone in your practice or organization, your licensing body and your professional association. The good news is that while the task may seem enormous, the dental community has begun to discuss the issue of family violence. Family violence guidelines for dental practice are being developed and should be available by 1995. An annotated bibliography of resource materials for the dental community is now available. Information on how to obtain this and other useful resources is listed below.



Useful Resource Information

• Family Violence Resource Materials for the Dental Community: An Annotated Bibliography, May 1993

Copies available from:
Publications, Health Canada
19th Floor, Jeanne Mance Building
Tunneys Pasture
Ottawa, Ont. K1A 0K9
Tel: (613) 954-5995 Fax: (613) 952-7266

• National Clearinghouse on Family Violence

Health Canada
Ottawa, K1A 1B5
Tel: 1-800-267-1291 Fax: (613) 941-8930

The National Clearinghouse on Family Violence is an excellent source for material on all forms of violence in the family. The following two resources are available free of charge, in either French or English from the Clearinghouse:

• Family Violence: Clinical Guidelines for Nurses

This booklet provides an easy -to-use guide for all health practitioners. All forms of violence in families are discussed and guidelines for identification are included.

• Wife Abuse — A Workplace Issue: A Guide for Change

The Guide provides practical resources, training ideas and workshop outlines adaptable for use in any workplace setting. Women's words, stories and ideas for action are incorporated into the material and reinforce the urgency and the necessity for making workplaces more supportive to abused women.

• Taking Action: A Union Guide to Ending Violence Against Women

This is an excellent publication from the Women's Research Centre and the B.C. Federation of Labour. Although the booklet was produced initially for union counselors it would be an extremely useful resource for anyone who is interested in making family violence issues workplace issues.

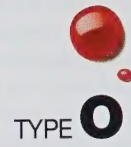
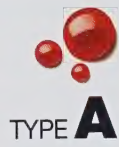
For ordering information contact:
Women's Research Centre
#101 - 2245 West Broadway
Vancouver, BC V6K 2E4
Tel: (604) 734-0485 Fax: (604) 734-0484

• Vis a Vis... A National Newsletter on Family Violence

Vis a Vis is published quarterly in both French and English by the Family Violence Program of the Canadian Council on Social Development. It provides up-to-date information on new resources, programs, conferences and research in the field of family violence.

Subscriptions to *Vis a Vis* are available free of charge through:

Family Violence Program
Canadian Council on Social Development
55 Parkdale Ave
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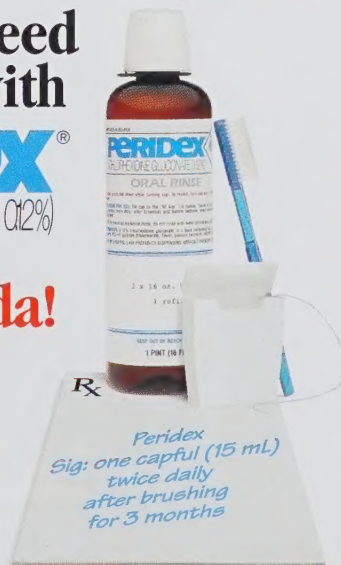
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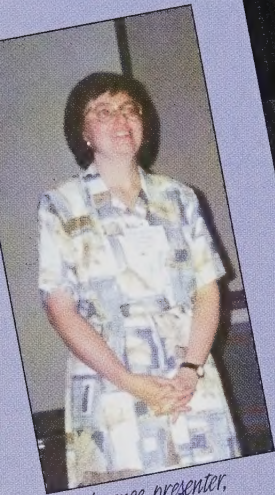
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Conference '94



Conference presenter,
Lynn Guest



Boomtown Welcoming Committee



CDHA President, Fran Richardson
Cotton (right) and Chair of Member
Services, Aileen Seed, congratulate
AquaFresh Student Scholarship Award
Winner Dorothy Cairns



1994 CDHA Local Conference
Co-Chairs Maureen Bowerman
(left) and Barb Long (right)



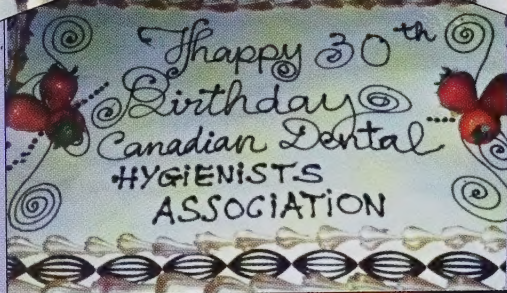
Behind every great smile...
a dental hygienist!



SDHA Local Organizing Committee



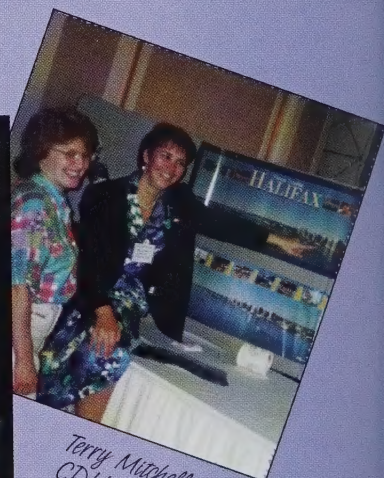
On the bus to oblivion?!



Hollywood's loss is
the Dental Hygiene
profession's gain!



Conference participants mesmerized by the activity at the Commercial Exhibits.



Terry Mitchell, Local Chair for
CDHA's 6th Annual Professional
Conference (Halifax, NS) points
out Halifax attractions

By:

Dianne Landry, RDN, MDN, BA, BV/TEd

I had the dubious honour of being the last speaker, at the last scientific session, on the last day of a very successful CDHA professional conference.

I was amazed and gratified by the stamina of the people in attendance that afternoon. I view this as a tribute to the efforts of the conference organizers which resulted in an interesting, thought-provoking, educational and downright entertaining three days.

My goal when attending any continuing education activity is to acquire at least one good idea and then put it into practice when I return home. The speakers, whose presentations reflected the conference theme, "SHARPEN YOUR PROFESSIONAL EDGE: A QUESTION OF CONSCIENCE — A MATTER OF CHOICE", provided a wealth of information from which to extract great ideas. They also conducted workshops that allowed us the opportunity to put these ideas into practise immediately.

From the opening remarks of Louise Simard, Saskatchewan's Minister of Health to the panel discussions on the last day, all the speakers echoed the fact that the dental hygienist has an important contribution to make to good oral health which is an integral part of the total health and wellness of all Canadians.

As the conference proceeded it became evident that the two current trends influencing the position of the dental hygiene profession in the delivery of oral health care are: health care reform policies and legislative changes governing dental hygiene practice.

Health care reform in Canada will succeed only through a multidisciplinary approach that will remove or at least reduce the financial, public policy and legislative barriers that prevent people from gaining access to adequate care. Dr. Michael Rachlis, in his presentation, promoted "anticipatory primary care". Anticipate the need of Canadians and then deliver the care more effectively and efficiently. He said, in order to create an environment for change or reform that will succeed, we need to change the public's belief about what good health is, let them know how their tax dollars are being spent and what institutional factors are controlling the decision making process. It was refreshing to hear a member of the medical profession taking his colleagues to task, for the selfish way in which they have been controlling the health care industry to the detriment of Canadians, both economically and health-wise. He urged dental hygienists to promote their philosophy of, and expertise in, the delivery of primary oral health care for all Canadians.

The other trend discussed that has the potential to forever change the practice of dental hygiene was self-regulation. The key issue of self-regulation of a profession is that it better serves the public interest. Self-regulation should not be, as Brent Cotter's story of the community of mice governed by cats illustrated, for the sole benefit of those in control of the laws that regulate the profession. Inextricably attached to the notion of self-regulation are several responsibilities and challenges. **WE ARE ASSUMING A PERSONAL RESPONSIBILITY TO PROTECT OUR PROFESSION "IN THE PUBLIC'S BEST INTEREST"!**

We will experience conflicts of interest, oral health care dilemmas, a stark exposure to public criticism and an accountability never before experienced. It was stated at the conference that ethical dilemmas would "exponentially develop" with self-regulation and that it would be ridiculous not to expect this to happen.

Rather than fear or try to avoid the added responsibilities and challenges of a self-regulated profession, the dental hygienists at the professional conference immersed themselves in the process of revising, developing and validating their critical thinking and communication skills, decision-making models, and their ethical awareness.

Maxine Borowko and Lynn Guest described their role as community health dental hygienists who provide oral health care to the mentally challenged. This unique dental hygiene practice setting, initiates new and different methods of communication, education and treatment plans, not only for the client, but for other health professionals as well. They are actively involved in the multidisciplinary approach to health care that is being promoted.

Marg Wilson and Jenny Thomas skilfully led over 100 dental hygienists through a practical application of an ethical decision-making model. The development of the process was likened to the building of a "House of Life" upon which professional and ethical decision-making depends. The walls and foundation of our house are represented by society's expectations of the professional, client/consumer rights, a professional code of ethics, our science/knowledge and the laws. Ultimately only you can make the choices for your actions and only you are responsible for the consequences of your decisions.

During the week, Dr. Chiodo and various panel discussions also centered around the theoretical constructs and practical applications of teaching and learning ethics. It was generally agreed that health care ethics must be taught.But can they be learned? The participants at the conference benefited from the speakers' expertise as they shared their knowledge, insights and personal experiences of how ethics can be both taught *and* learned.

Pamela Wallin of CBC's Prime Time News captivated the audience as she spoke of broadcasting's responsibility to make ethical and moral decisions about choosing what will hit the air waves. She said that democracy was one of the basic tenets of journalism. The people have the right to know. But the power of technological advances in telecommunications to mirror the reality, can at the same time, mould our society. However she hastened to assure us that television is not the cause of all our ills. "It is said that television is a mirror of society, but if an ass peers into it, you cannot expect an apostle to peer out". She believes that a whole new social contract is being written, and social relationships are changing not only here, but globally. The citizenship has a responsibility which they need to take a little more seriously.

The more serious, mind-enhancing conference program was also carefully balanced with some relaxing, fun, sometimes brain-numbing events. Receptions, award presentations, skits and a gastronomically spectacular "prairie dinner" at BOOMTOWN, Saskatchewan gave us the chance to change gears and regroup for the next day's scientific sessions.

Many Easterners and Westerners enjoyed the open, friendly hospitality extended by the "FLATLANDERS". Those who are not privileged to be from the prairies caught a glimpse of its soul. Though we did not experience a blizzard, together we fought the cold, the wind, the rain storms, the mosquitoes and shared the blazing sun.

It must be the clarity of the light of the big sky country that enabled so many dental hygienists to come away, once again rejuvenated, and proud to be a part of a profession on the threshold of exciting times.



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Introduction

We are pleased to debut this new regular column in *Probe* this month, following on the heels of CDHA's 5th Annual Professional Conference that focused on ethics. Each ethical dilemma presented has been encountered by a dental hygienist in the workforce. Dental hygienists were interviewed by second year dental hygiene students at Dalhousie University, Halifax, Nova Scotia, as a class assignment. The students recorded, analyzed and documented the dilemmas they discovered out in the field. The names used within the columns are fictitious, but the incidents are **real**. Sometimes the dilemmas have been re-worked slightly, by the authors, to increase the learning application.

The format of this column is designed to help you learn from the documentation being presented. Each ethical dilemma will present the pertinent facts as reported

when the situation was being explored. The ethical principles involved in the dilemma are identified using the CDHA Code of Ethics; possible solutions (options) to the dilemma will be stated and critiqued. The authors will then determine what they consider to be the most ethical choice and indicate how they would implement their decision.

You may not always agree with the choice the authors make and we welcome your comments. Feel free to share **your** solutions with the readership. Furthermore, if you have encountered an ethical dilemma in your practice and would like to share both the situation and the resolution with us, please do so — chances are strong that someone else out there is having (or has had) the same problem.

The Dilemma

Jane Miller is a new patient to Dr. Drysdale's office. She had not seen a dentist/dental hygienist for approximately 20 years. Ms. Miller's initial appointment was booked for a routine 45 min. "cleaning" with the dental hygienist, Susan White. A periodontal assessment revealed that Ms. Miller had moderate periodontitis, abundant calculus and plaque and required additional treatment time. The hygienist completed the 45 min. appointment, then worked an additional 45 min. into her lunch hour. The dentist examined the patient's mouth and said, "You're done...see you in six months".

The hygienist knew that the treatment was not complete. She told the dentist this and his response was, "That calculus has been there for 20 years and another six months won't hurt." He said he was afraid he would lose the patient because the scaling was taking too long, and he did not want to ask the patient to come in for another appointment the following week.

The hygienist refused to write in the chart that she had finished the patient. She had not provided any patient education. She recorded exactly what had happened in the patient's chart, much to the displeasure of the dentist.

1. Gather The Facts

- Ms. Miller is a new patient.
- She had not seen a dentist for 20 years.
- She was booked for a 45 min. appointment with the hygienist.
- The patient presented with moderate periodontitis with large accumulations of calculus and plaque.
- The hygienist worked for 1 1/2 hours on the patient.
- The dentist released the patient before the hygienist was finished.
- No patient education had been provided.
- The patient has been scheduled to return in six months.
- The dentist is afraid of losing the patient.
- The hygienist accurately recorded in the chart that the treatment was not completed.
- The dentist was unhappy that this had been recorded in the patient's chart.

2. Identify The Relevant Values (from C.D.H.A. Code of Ethics)

Responsibilities to the client:

Principle 3: Veracity and Informed Consent

In this case the patient/client was not an active participant in deciding what

her treatment options were, and she was not adequately advised of her periodontal condition.

Principle 4: Beneficence and Quality Assurance

- 4a. The patient did not receive any oral hygiene instruction or patient education.
- 4b. The hygienist was not consulted regarding the dental hygiene treatment plan and the decision to suspend treatment for six months.

Principle 5: Justice

The hygienist did record accurately in the patient's chart the treatment she received, but did not take an appropriate course of action to ensure competent ethical care for the patient.

3. Explore the Options

1. Explain the situation to the patient, explain all the options available, and have her decide what course of treatment she would prefer.
(This solution addresses all of the ethical principles involved but would likely create a conflict between the dentist and the hygienist that could result in loss of employment for the hygienist.)
2. Discuss the issues with the dentist first, then follow option #1.
(This solution addresses all of the ethical principles, and may avoid conflict with the dentist if he can be persuaded to go along with option #1.)

3. Let the patient go and recall her in six months.
(This solution violates principles 3, 4, & 5, but keeps peace in the office.)
4. Charge the patient less since the treatment is incomplete.
(This solution gives the patient a financial break, but still does not address principles 3, 4, & 5.)
5. Recall the patient in three months instead of six months.
(This solution is an improvement over the six month recall but still does not address the ethical principles involved.)
6. Rebook the patient for a 15 min. patient education appointment.
(This solution addresses the principle of Beneficence and Quality Assurance (4a.) but not the other principles.)

4. Choose An Option

In this case I would choose Option 2. The hygienist could present her case to the dentist, and hopefully come to a positive resolution. The patient could be re-booked for a consultation where she is advised of her periodontal condition, and the treatment options that are available to her outlining the risks and benefits of each option. The patient is then able to make an informed choice about the treatment that best suits her circumstances.

5. Implement Your Choice

I would act as described under "Choose an Option". If the dentist was inflexible in his decision, I would then have to decide whether to go along with his decision, bring the patient in anyway, report the case to the provincial dental board, or quit my job. It is always important to remember that the needs of the patient/client should always come first, and that the most ethical choice is usually the one that addresses the majority of ethical principles involved in the dilemma.

Nancy Prowse received her Bachelor of Arts from Acadia University in 1971, a Diploma in Dental Hygiene from Dalhousie University in 1974 and completed her Masters of Education from Dalhousie University in 1989. She has practiced clinical dental hygiene in specialty and general practices, and hospital and public health settings in Ontario and Nova Scotia. She joined the Faculty of Dentistry at Dalhousie University in 1985 where she is now the second year dental hygiene clinic coordinator and course director for Professional Issues. She has been involved in the teaching of Ethics since 1987 and chaired the CDHA committee to revise the Code of Ethics.

Brenda Fortune received her Diploma in Dental Hygiene from Dalhousie University in 1974. She has practiced clinical dental hygiene in Ontario and Nova Scotia. She joined the Faculty of Dalhousie University in 1989 where she has been involved in teaching clinical dental hygiene, and organizing and supervising the extramural program for the Community Oral Health course. She has taught Ethics since 1990 and is currently the Course Director. In addition she was a member of the committee that revised the CDHA Code of Ethics.

PERIDEX® (CHLORHEXIDINE GLUCONATE 0.12%)

PERIDEX ORAL RINSE
(Chlorhexidine Gluconate 0.12%)
Antigingivitis Oral Rinse

ACTIONS, CLINICAL PHARMACOLOGY: Peridex Oral Rinse (0.12% Chlorhexidine Gluconate) or Peridex provides antimicrobial activity during oral rinsing which is maintained between rinsings. Microbiologic sampling of plaque has shown a general reduction of both aerobic and anaerobic bacterial counts ranging from 54-97% through six months' clinical use. Rinsing with Peridex inhibits the buildup and maturation of plaque by reducing certain microbes regarded as gingival pathogens, thereby reducing gingivitis. Peridex provides antimicrobial activity during rinsing and for several hours thereafter.

No significant changes in bacterial sensitivity, overgrowth of potentially opportunistic organisms or other adverse changes in the oral microbial flora were observed following the use of Peridex for six months. Three months after Peridex use was discontinued, the number of bacteria in plaque had returned to pre treatment levels and sensitivity of plaque bacteria to chlorhexidine gluconate remained unchanged.

Studies conducted with human subjects and animals demonstrate that any ingested chlorhexidine gluconate is poorly absorbed from the gastrointestinal tract. Excretion of chlorhexidine gluconate occurred primarily through the feces (approximately 90%). Less than 1% of the chlorhexidine gluconate ingested by these subjects was excreted in the urine.

INDICATIONS AND CLINICAL USE: Peridex is indicated for use as part of a professional program for the treatment of moderate to severe gingivitis, and for management of associated gingival bleeding and inflammation between dental visits. For patients having coexisting gingivitis and periodontitis, see PRECAUTIONS.

CONTRAINDICATIONS: Peridex should not be used by persons who are known to be hypersensitive to chlorhexidine gluconate or other formula ingredients.

WARNINGS:

USE IN PREGNANCY: Reproduction and fertility studies with chlorhexidine gluconate have been conducted. No evidence of impaired fertility was observed in male and female rats at doses up to 100 mg/kg/day, and no evidence of harm to the fetus was observed in rats and rabbits at doses up to 300 mg/kg/day and 40 mg/kg/day, respectively. These doses are approximately 100, 300, and 40 times that which would result from a person ingesting 30 mL (2 capfuls) of Peridex (0.12% chlorhexidine gluconate) per day. Since controlled studies in pregnant women have not been conducted, the benefits of use of the drug in pregnant women should be weighed against possible risk to the fetus.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. In parturition and lactation studies with rats, no evidence of impaired parturition or of toxic effects to suckling pups was observed when chlorhexidine gluconate was administered to dams at doses that were over 100 times greater than the dose which would result if a person ingested the entire recommended dose of Peridex (0.12% chlorhexidine gluconate) on a daily basis.

USE IN CHILDREN: Since the safety and efficacy of Peridex in children has not yet been fully established, the benefits of its use should be weighed against the possible risks.

PRECAUTIONS:

1. For patients having coexisting gingivitis and periodontitis, the absence of gingival inflammation following treatment with Peridex may not be indicative of the absence of underlying periodontitis. Appropriate treatment of periodontitis is therefore indicated.

2. Peridex may cause staining of oral surfaces such as the film on tooth surfaces, restorations, and the dorsum of the tongue. Stain will be more pronounced in patients who have heavier accumulations of unremoved plaque.

Stain resulting from use of Peridex does not adversely affect the health of gingivae or other oral tissue. Stain can be removed from most tooth surfaces by conventional professional prophylactic techniques. Additional time may be required to complete the prophylaxis.

Discretion should be used when treating patients with exposed root surfaces or anterior facial restorations with rough surfaces or margins. If natural stains cannot be removed from these surfaces by a dental prophylaxis, patients should be excluded from Peridex treatment if the risk of permanent discolouration is unacceptable. Stains in these areas may be difficult to remove by dental prophylaxis and on rare occasions may necessitate replacement of these restorations.

3. A few patients may experience a slight and temporary alteration in taste perception while undergoing treatment with Peridex. Most of these patients accommodate to this effect with continued use of Peridex.

4. For maximum effectiveness the patient should avoid rinsing their mouth, eating or drinking for about 30 minutes after using Peridex.

ADVERSE REACTIONS: No serious systemic reactions associated with use of Peridex were observed in clinical testing. However, some adverse reactions have been reported in studies with Peridex or other chlorhexidine-containing mouth rinses. The most common side effects associated with chlorhexidine gluconate oral rinses are (1) an increase in staining of oral surfaces, (2) an increase in supra gingival calculus and (3) a slight and temporary alteration in taste perception. (see PRECAUTIONS). Epithelial irritation and superficial desquamation of the oral mucosa have been noted in studies of children using 0.12% chlorhexidine gluconate which were reversible upon discontinuation.

There have been rare cases of parotid gland swelling and inflammation of the salivary glands, in patients using Peridex.

SYMPTOMS AND TREATMENT OF OVERDOSAGE: Ingestion of 30 or 60 mL of Peridex (0.12% chlorhexidine gluconate) by a small child (10 kg or less body weight) might result in gastric distress, including nausea, or signs of alcohol intoxication. Medical attention should be sought if more than 120 mL of Peridex is ingested by a small child or if signs of alcohol intoxication develop.

DOSAGE AND ADMINISTRATION: Peridex therapy should be initiated directly following a dental prophylaxis. Patients using Peridex should be reevaluated and given a thorough prophylaxis at intervals no longer than six months; they should be referred for periodontal consultation as necessary.

Recommended use is twice daily oral rinsing for 30 seconds, morning and evening after tooth brushing. Usual dosage is 15 mL (marked in cap) of undiluted Peridex. Peridex is not intended for ingestion and should be expectorated after rinsing. Rinsing the mouth, eating or drinking should be avoided for about 30 minutes after using Peridex.

The suggested initial course of therapy is 3 months, at which time patients should be recalled for evaluation. At the time of the recall visit, the dental professional should:

- Evaluate progress, remove any stain, and reinforce proper home care techniques.

- If gingival inflammation and bleeding is controlled, discontinue Peridex therapy and recall the patient in three months to assess gingival health.

- If gingival inflammation and bleeding persists, continue Peridex therapy for an additional 3 months and schedule a three-month recall for evaluation.

- Evaluate for evidence of epithelial irritation, desquamation and parotitis.

The following generally accepted grading scheme may be of use in evaluating the severity of gingivitis.

Loe and Silness
GINGIVAL INDEX (GI)

Grade	Description
1	Normal gingiva, no inflammation, no discoloration, no bleeding.
2	Mild inflammation, slight color change, mild alteration of gingival surface. No bleeding.
3	Moderate inflammation, erythema, swelling, bleeding on probing or when pressure applied.
4	Severe inflammation, severe erythema and swelling, tendency toward spontaneous hemorrhage, some ulceration.

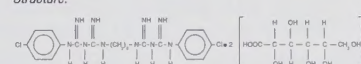
An occasional missed dose can be ignored if the patient is generally compliant with the prescribed regimen.

PHARMACEUTICAL INFORMATION DRUG SUBSTANCE

Proper Name: Chlorhexidine gluconate (U.S.A.N.)

Chemical Name: 1,1'-hexamethylene bis [5- (p-chlorophenyl) biguanide] di-D-gluconate

Structure:



Molecular Weight: 897.8

Description:

Chlorhexidine has basic character and exists in the di-cationic form at physiologic pH. The two protonic positive charges become somewhat localized on the bi-guanide portion of the molecule. Both pKa's are reported as 10.78 ± 0.06. The gluconate salt is soluble in excess of 70% (w/v) in water at 20°C.

At 19-21% w/v chlorhexidine gluconate solution is colourless to pale straw-coloured and is odourless to almost odourless (British Pharmacopoeia).

COMPOSITION: Peridex contains 0.12% chlorhexidine gluconate in a base containing water, alcohol, glycerin, PEG-40 sorbitan di-isostearate, flavour, saccharin sodium and FD&C Blue #1 Dye.

STABILITY AND STORAGE: Store above freezing (0°C).

INCOMPATIBILITIES: None known.

SPECIAL INSTRUCTIONS: None.

AVAILABILITY OF DOSAGE FORM: Peridex oral rinse (0.12% chlorhexidine gluconate) is supplied as a blue liquid in 475 mL amber plastic bottles with child-resistant dispensing closures.

Store above freezing (0°C).

REFERENCE

1. Grossman E., Reiter G., Sturzenberger OP, et al. Six-month study of the effects of a chlorhexidine mouthrinse on gingivitis in adults. *Journal of Periodontal Research*. 1986;21(suppl 16):33-43.

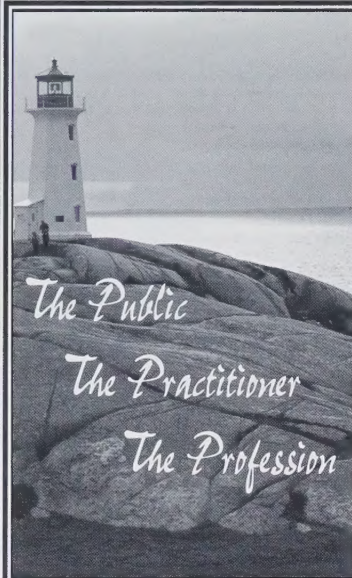
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CALL FOR ABSTRACTS

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CANADIAN DENTAL HYGIENISTS ASSOCIATION

announces its

6th Annual Professional Conference

June 16-18, 1995 • The Sheraton Halifax • Halifax, Nova Scotia

Submissions of abstracts for free papers, posters, and table clinic presentations which are related to any aspect of dental hygiene practice are invited. Your intent to submit an abstract, including your name and title of the abstract, must be made known to the CDHA Conference Co-ordinator by December 15, 1994.

The deadline for submissions of abstracts for free papers, posters and table clinics is February 15, 1995. Selection will be on the basis of the quality of abstracts. Notification to authors of accepted or rejected abstracts will be made by March 15, 1995. All selected abstracts will be published in the Conference Program.

Completed papers must be submitted by April 10, 1995 for potential publication in Probe, CDHA's scientific journal.

For additional information contact: CDHA Central Office, 201-1018 Merivale Rd., Ottawa, ON, K1Z 6A5

Authors should submit one copy of Appendix A by February 15, 1995.

Appendix A for Abstract

CDHA's 6th Professional Conference

The Public, The Practitioner, The Profession

Halifax, Nova Scotia
June 16-18, 1995

Deadline date for Abstracts:
February 15, 1995.

First Author: _____

Affiliation: _____

Address: _____

City _____ Prov./State _____

Postal/Zip Code _____

Telephone: Bus. () _____

Res. () _____

Additional Authors (Names Only)

It is expected that first authors will present the papers unless otherwise specified.

Choice of Presentation Format

_____ Oral presentation (Free Paper)

_____ Poster presentation

_____ Table clinic

Abstracts should be submitted to:

c/o Canadian Dental Hygienists' Association
Ste. 201, 1018 Merivale Rd.
Ottawa, Ontario, Canada
K1Z 6A5

Type perfect original of abstract here. Do not type beyond outline of box.
Include title, purpose, method & results.



Canadian Dental Hygienists Association

HALIFAX

Sixth Annual Professional Conference

For more information call 1-800-267-5235

Preliminary Program

Friday, June 16

- 1:00 - 1:30 Conference Opening
Opening Remarks/Greetings
- 1:30 - 3:15 **Jane Fulton, PhD**
- 3:15 - 3:30 Break
- 3:30 - 5:00 **1 of 3 choices!**
Choong Foong, BSc (Hon) PhD on
Medical Histories & Pharmacology
or
JoAnn Gurenlian, RDH, PhD on Lasers
or
Chris Gallant, MSc, MD, FRCP(C) on
Dental Hygiene Dermatology Issues

Evening: President's Reception

3:45 - 4:00 Break

- 4:00 - 5:00 **2 choices**
Burglind Gregg, Dip DH, BA, LLB on
the Legalities of Recordkeeping
or
Kimberly Krust-Bray, RDH, MS on
The Role of Local Drug Delivery and
the Changing Role of Ultrasonics

Sponsored DENTSPLY
by: CANADA

Evening Social Event (including a Meal and
Entertainment (More details to follow
in future issues of *Probe*))

Saturday, June 17

- 7:30 - 8:30 Continental Breakfast
- 8:30 - 10:00 **1 of 2 choices**
Barbara Harsanyi, BA, DDS, MS FRCD(C)
on Oral Pathology
or
JoAnn Gurenlian, RDH, PhD on
Diagnostic Decision-Making
- 10:00 - 11:30 Free Paper Presentations
and
- 10:00 - 2:00 Commercial Exhibits
- 11:30 - 2:00 Lunch
- 2:00 - 3:45 Panel Discussion on Self-Regulation
featuring: **Brenda Walker, RDH** of the
Alberta Dental Hygienists Assn

Sunday, June 18

- 7:30 - 8:30 Continental Breakfast
- 8:30 - 10:00 **Dan Boland, MSc (PT), MCPA** and
Shirley McCarthy, BSc (OT), Reg (NS) on
Preventing & Managing Injuries in
the Workplace
and
10:00 - 11:30 **Christine Robb, Dip DH, BA** on
Ethics and Infection Control
or
8:30 - 11:00 **Kimberly Krust Bray, RDH, MS** on
Periodontal Debridement

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11:00 - 12:30 Awards Brunch

		SPONSOR	LOCATION	FOR INFO CALL
October 1994				
2-8	Fédération Dentaire Internationale	Canadian Dental Association	Vancouver, BC	(613) 523-1770
13	Emerging Issues in Infectious Diseases for Dental Hygienists — TB and Hepatitis C — Joel Epstein, DMD, MSD Rick Mathias, MD, FRCP Peter Riben, MD, MHSc, FRCPC	University of British Columbia	Vancouver, BC	(604) 822-2626
14-15	The Paper Chase — Record Keeping	Ontario Dental Hygienists Association	London, ON/ Richmond Hill/ON	(905) 681-8883
15	Clinical Pharmacology Update: Important Facts That Protect Your Patients and Practice — Harold L. Crossley, DDS, PhD	Dalhousie University, Faculty of Dentistry	Acadia University, Wolfville, NS	(902) 494-1674
15	Medical History — Why Do We Care? Lumps and Bumps — Oral Pathology in the Real World — Dr. Trey Petty	The Southern Alberta Dental Hygienist Society	Foothills Hospital, Calgary, AB	Barbara at (403) 283-0060
15-16	Local Anaesthesia for Dental Hygienists	University of British Columbia	Vancouver, BC	(604) 822-2626
15-22	Periodontics Update for Dental Hygienists	Algonguin College	Ottawa, ON	(613) 727-9797
22	Local Anesthesia: A Refresher for Dental Hygienists	NAN-KES: Partners in Education	Vancouver, BC	(604) 942-5785
November 1994				
1	Managing Life with Choices, Changes & Chuckles — Cyndy Stevenson	The Southern Alberta Dental Hygienist Society	Foothills Hospital, Calgary, AB	Barbara at (403) 283-0060
3	Alcohol & Pregnancy: Identifying the Risks — Christine Looch, MD, FRCPC, FAAP	University of British Columbia	Vancouver, BC	(604) 822-2626
4-5	Local Anaesthesia for Dental Hygienists	University of British Columbia	Vancouver, BC	(604) 822-2626
19	X-Ray X-Cellence — Part I — Barry Pass, DDS, MSc, PhD & Tom Blackmore, B.Eng., DDS	Dalhousie University, Faculty of Dentistry	Dalhousie University, Halifax, NS	(902) 494-1674
December 1994				
3	Incorporating Periodontics into General Practice — William J. Killoy, DDS, MS, FACD	Dalhousie University, Faculty of Dentistry	Dalhousie University, Halifax, NS	(902) 494-1674
3-6	VI General Dental Hygiene Congress	Spanish Dental Hygienists Federation	Valencia, Spain	(96) 342 04 22
1995				
November	13th International Symposium on Dental Hygiene <i>If you want to be on the mailing list for announcements and program information write to:</i> The Japanese Dental Hygienists' Association c/o Shikaishi Kaikan, 4-1-20 Kundankita, Chiyodaku, Tokyo 102 - Japan	Tokyo, Japan		

STUDENT SCENE



Dental hygiene students from Georgian College, Orillia Ontario, celebrated "World Health Day — Oral Health" (April 1, 1994) by staffing an information booth on campus. The students also entertained children at the Georgian College Day Care Center, with a puppet show on "Healthy Teeth". The students involved were Pam Archer, Andrea Ferrier, Jennifer Parkinson and Brenda Walters. The day was a success thanks to the efforts of the students and donations from various sponsors. (Thanks to Linda Jamieson, Coordinator, Dental Programs, Georgian College for providing the photos.)



Reviewed by:
Carol Barr Overholt, RDH

Long-Term Effect of Two Preventive Programs on the Incidence of Plaque and Gingivitis in Adolescents

By: **Jasim M. Albandar,**
Yvonne A.P. Buischi,
Marcia P.A. Mayer,
and **Per Axelsson.**
Journal of Periodontology, June 1994

It is currently accepted that the primary etiological factor in gingivitis and periodontitis is bacterial plaque. The resultant breakdown is dependent upon the relationship between the pathogenicity of the plaque and the host resistance factors. This suggests that careful plaque removal may result in a reduction in the prevalence and progression of periodontitis and in the prevention of alveolar bone loss.

This study was designed to determine the efficacy of self-delivered plaque control in averting gingival inflammation in adolescents.

The three-year study exposed 227 Brazilian children to two oral hygiene programs. The first group received extensive dental health education, based upon an individual needs assessment, coupled with 25-minute information sessions on the etiology/prevention of dental diseases. Parents and teachers were included in these sessions. The students were taught how to assess their own bleeding and plaque levels and were shown how to use disclosing solution. Intraoral instruction included the demonstration of the Bass toothbrushing method and flossing. The children deplaqueed once daily; flossing was followed by brushing and disclosing. Supervision provided encouragement and motivation.

The second group received a five-minute oral hygiene session demonstrating brushing and flossing on a study model. The brushing sequence was not outlined. Group sessions and parental involvement were absent. The children in both test groups received a toothbrush, dental tape and a toothpaste containing fluoride. A third group provided a negative control. The children were examined at baseline and annually over three years.

All children involved in the study showed a continued improvement in their oral hygiene and gingival health. The first group, who

received the more extensive program of instruction, showed significant improvement over the control group. The second group, that followed the less comprehensive model, did not significantly differ in results from the control group.

The authors indicated that children with initially higher plaque and gingival inflammation scores showed less positive results; girls demonstrated greater improved results than boys; the longer the exposure to the program, the more improved the results.

In conclusion, comprehensive oral hygiene instruction and education can be productive in sustaining adolescent gingival health.

Evaluating Spatter and Aerosol Contamination During Dental Procedures

By: **Carolyn D. Bentley DDS,**
Nancy W. Burkhart RDH, M.Ed.,
James J. Crawford MA, Ph.D.
Journal of the American Dental Assoc. (JADA), May 1994

With the increased concern for the potential transmission of disease during dental procedures, the authors have examined the distribution of spatter or mist, aerosol-borne contaminants.

Prior research supports the fact that air and water-borne oral and respiratory tract microorganisms pose a threat to the eyes, mucous membrane/skin, and respiratory tracts of dental personnel. Some microflora have even reached the depth of the lungs. With a resurgence in the prevalence of tubercular infections, concern regarding transmission of this mycobacterium has arisen. The Centers for Disease Control have indicated that strains of the tubercular bacterium are becoming resistant to anti-TB medications. There is no documentation to support that hepatitis-B (HBV) or HIV infections can be communicated through aerosol/mist inhalation.

Spatter, containing larger sized droplets, may include blood-borne bacteria, viruses and respiratory/salivary secretions. HIV and HBV transmission therefore become a concern to dental personnel.

This study was designed to measure aerosol and spatter contamination in a dental office

using high-speed equipment accompanied by high-volume evacuation (HVE), with the client reclined in the dental chair. The procedures were divided into two phases.

Fluorescent dye was added to the water supply and filter-paper discs were distributed throughout the operator to detect the presence of mist-borne contamination. Restorative procedures were performed and an ultraviolet light source was used to detect the dye dispersion.

In the second phase of the experiment, blood agar culture plates were distributed throughout the operator and worn by the operator and personnel. Restorative procedures (accompanied by HVE) and ultrasonic scaling procedures (using a saliva ejector for evacuation) were performed. The petri dishes were then incubated and examined.

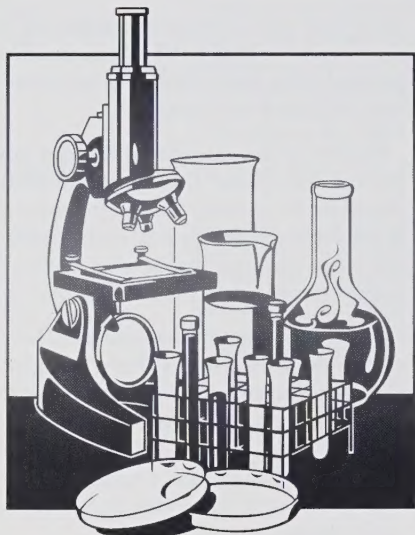
The dye travelled to the operator's chest, face and shoulders and "fell in a heavy rain on the lower arms". Evidence of mist was also found on the client's chest and on surfaces two feet, or greater, from the dental chair. Of greatest significance was that the dental personnel's face masks were coated with dye even in the presence of face shields.

The pattern or distribution of alpha haemolytic streptococci, arising from spatter, exhibited varied dispersion patterns dependent upon the area of the mouth being treated. High bacterial counts were similarly detected on the operator's mask and client's chest, although the bacterial spatter was "more widespread and less directional" than the dye mist.

During the ultrasonic scaling phase of the experiment, bacterial counts were lowered by having the client brush and floss prior to the procedure. Moderate contamination was evidenced on counters and bracket tables consistent with using a saliva ejector rather than an HVE.

The authors support previous research which documents that pre-procedural rinsing with an antimicrobial mouthrinse can significantly decrease the aerosol bacteria levels. Recommendations include the use of rubber dam, pre-operative brushing, universal barrier protection and multi-layered, high-filtration masks. These researchers indicate that further studies are necessary to determine more specific guidelines.

Clinical Dental Hygiene — Dentinal Hypersensitivity



1. Hypersensitive dentin is shown microscopically to have more numerous and wider tubules than in nonsensitive areas.
 - a) True
 - b) False
2. Sweet, sour or highly acidic foods, fluids of high osmolarity and plaque induce pain by:
 - a) thermal stimuli
 - b) chemical stimuli
 - c) mechanical stimuli
 - d) electrical stimuli
3. What professional procedures may result in tooth sensitivity?
 - 1) root surface scaling and planing
 - 2) gingival surgery causing root exposure
 - 3) cavity preparation
 - 4) placement of a crown
 - a) 1,2,3
 - b) 1,2
 - c) 3,4
 - d) all of the above
4. A procedure that increases the fluoride ion penetration into the dentin through electric current is:
 - a) laser treatment
 - b) application of fluoride varnish
 - c) acid etching and bonding
 - d) iontophoresis
5. Surface, sealing agents used in the treatment of hypersensitivity include all of the following except:
 - a) amalgam
 - b) bonding agents
 - c) cements
 - d) resins
 - e) varnishes
6. Treatment of hypersensitive teeth by reducing the size of the tubules may be accomplished by the following strategy(s):
 - a) form a smear layer by burnishing exposed root surface
 - b) apply topical agents that produce insoluble precipitates in the tubules
 - c) place plastic resin within the tubules to occlude the openings
 - d) apply bonding agents to seal the tubules
 - e) all of the above
7. The closure of dentinal tubules by mechanical blockage may result from all of the following except:
 - a) the formation of secondary dentin
 - b) coagulation; protein precipitation
 - c) surface coating
 - d) mineralization; building a calcific barrier
8. The most widely accepted theory of pain impulse conduction in dentinal hypersensitivity is:
 - a) nerve endings in dentin
 - b) hydrodynamic mechanism
 - c) odontoblast as a special sensory cell
9. The role of the dental hygienist in the treatment of dentinal hypersensitivity includes:
 - a) thoroughly investigate the patient's home care practices
 - b) observe patient's plaque removal techniques
 - c) investigate the patient's diet
 - d) all of the above
10. Professional products used in treating dentinal hypersensitivity include:
 - a) calcium hydroxide
 - b) silver nitrate
 - c) fluoride compounds
 - d) zinc chloride potassium ferrocyanide
 - e) all of the above

Reference: Woodall, Irene, Comprehensive Dental Hygiene Care, 4th Ed., Mosby, 1993.

This self-assessment test was prepared and submitted by Barbara Drewry and Melissa Schaefer of Camosun College.

Answers:

(P) 6	(b) 8	(e) 10
(e) 9	(a) 5	(7) 2
(d) 3	(2) b	(4) d
		(1) a

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Guided Tissue Regeneration

By:
Leanne D. Carlson-Mann, SDT, RDH

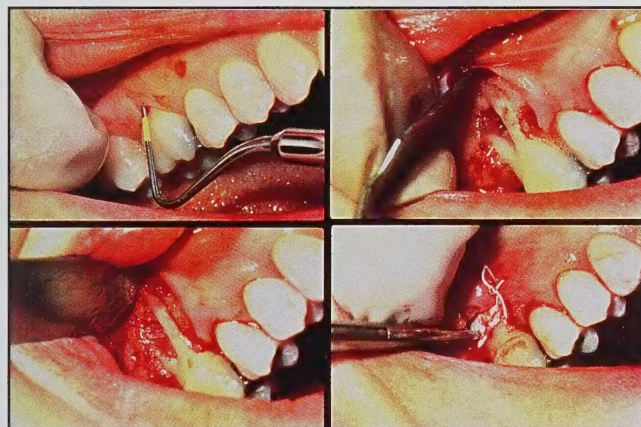


Figure 1

Top Left: Probing the furcation

Top Right: Exposing the defect

Bottom Left: Placing freeze-dried bone in furcation

Bottom Right: Placing GoreTex and using GoreTex sutures for the sling



Figure 2

Top Left: Flap closed with 4-0 silk sutures and surgical placed over top

Top Right: 8 months post-op

Bottom Left: Radiograph prior to G.T.R.

Bottom Right: Radiograph 8 months post-op

History

A fifty-five year old female with a history of periodontal abscess on the facial aspect on #16. Plaque control efficiency is 70% and the remaining teeth are periodontally sound. The patient experienced no discomfort from the area.

Examination

The patient is physically in good health. Tissue around tooth #16 was slightly inflamed and calculus was removed during initial scaling. A gross occlusal adjustment was also performed.

Measurements:

Cemento-enamel junction (CEJ) to

Free Gingival Margin (FGM) = 0

CEJ to Base of Pocket = 7mm.

FGM to Base of Pocket = 7mm.

Facial aspect of Buccal root surfaces to
depth of furcation on horizontal plane = 4mm.

Treatment Options

1. Scaling and root planing and maintenance.
2. Open flap debridement.
3. Apically repositioned flap and osteoplasty to facilitate home care procedures (ie. proxabrush).
4. Guided tissue regeneration (G.T.R.)

Treatment of Choice

Patient elected G.T.R. as treatment of choice despite additional cost and time.

Surgical Procedure

1. Sulcular incision and full thickness facial flap.
2. Soft tissue debridement.
3. Root planing.
4. Placement of decalcified freeze-dried bone in furcation to act as space maker and possibly as osseointductor.
5. Using sling suture technique, membrane is placed to completely cover defect and overlap alveolar crest adjacent to defect by 3-4mm.
6. Attempts are made to cover membrane completely by coronally repositioning flap.
7. Patient is placed on 500mg of Ampicillin every 6 hours for 7 days.
8. Patient is instructed to use chlorhexidine rinse 2 times a day for 7 days.
9. Patient is seen in one week.
10. Membrane is left for 4-6 weeks and is removed with a gentle tug or is surgically freed.

Discussion

Studies indicate the placement of an occlusive membrane between a mucogingival flap and a root surface will prevent connective tissue from contacting root surfaces and favor healing from the periodontal ligament. In this way, regeneration of the periodontium is possible.

In controlled technical studies, sites treated with G.T.R. result in resolution of furcation defects in more than 90% as compared to 20% treated conventionally. Rather than having the repair of a wound that takes place during natural healing, we now have regeneration.



Figure 3 — Mandibular left 6 year molar with defect in furcation.



Figure 4 — Placing freeze-dried bone in defect.

Leanne received her diploma in Dental Therapy in 1981 and a diploma in Dental Hygiene in 1982 from WIAAS in Regina, Sask. She has been employed with Dr. C.G. Ibbott, a periodontist in Regina, since graduation. Leanne received her dental implant training at the University of Washington in 1988 and has been extensively involved with implant procedures. As well as teaching and providing continuing education courses (primarily in Western Canada), Leanne teaches a dental implant class to the second year dental hygiene students at SIAST. Students this year were the first to receive an accredited hands-on prosthetic course in cooperation with Nobelpharma. Leanne has published a number of articles in *Probe*, the *CDA Journal* as well as co-authoring articles for various international journals.

Results of Treatment

Best results occur when G.T.R. is used in mandibular Grade II defects and maxillary Grade II defects. (There are three levels of Grade defects: Grade I defects are incipient (ie. they can't be probed very much), in a Grade II defect one can probe into the furcation but not through it, and Grade III defects can be probed right through to the furcation.) Maxillary molars are more challenging because interproximal furcations are hard to detect. Sometimes a Grade II defect is actually a Grade III when surgically exposed.

Most furcations treated with G.T.R. do not regenerate bone but have a rubbery probing attachment. Dense firm connective tissue can be observed 6 months post-operatively.

Approximately 1mm. of gingival recession after the procedure is observed and probing depths are reduced by 3mm.



Figure 5 — Placing Guidor resorbable membrane.



Figure 6 — Membrane in place and flap sutured.

Case Studies are presented for the interest of our members. However, CDHA is not endorsing any specific interventions.

We welcome submissions of this nature from our members to encourage an exchange of information.

National Dental Hygiene Campaign

The National Dental Hygiene Campaign is the responsibility of CDHA's Health Promotion Council.

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This module discusses the changing demographics and the oral needs of the older adult. Highlighted are oral manifestations of aging; the potential effects of medication impacting oral health, communication techniques appropriate for the older adult, and care of prostheses.

CDHA wishes to extend its thanks to Procter & Gamble for making copies of the new Education Series Module available to dental hygiene programs across the country, all dental hygiene provincial associations and the Armed Forces dental program.

In January 1994, CDHA's Professional Development Council surveyed dental hygiene educators to get their reactions to the initial P & G Education Series which were forwarded to Dental Hygiene Programs across Canada in the fall of 1993. According to the survey results, all modules were utilized by educators and a majority of respondents (74%) indicated they used the Series on an occasional basis while 16% reported using them regularly. More than 65 dental hygiene educators confirmed they had used the Series at one time or another. Comments about the series included, "very professional", "current", "top quality slides", "easy to use" and "great pre and post tests". Suggestions for future modules included special needs patients, oncology, oral pathology and ethics.

MANUSCRIPT SUBMISSION GUIDELINES

Introduction

PROBE is the official publication of the Canadian Dental Hygienists Association (CDHA). It is a scientific journal published on a bi-monthly basis.

As CDHA's official publication the objectives to be met by the publication are as follows:

- To report, chronicle and promote activities of scientific and professional interest to members of the Dental Hygiene profession.
- Through this publication, CDHA endeavours to foster the publication of original research in an effort to cultivate and sustain the art and science of Dental Hygiene practice.

Appropriate articles include original, unpublished reports of scientific research, literature reviews and theoretical manuscripts detailing new knowledge, insights or interpretations. Short reports (up to 2000 words), such as case studies, commentaries or educational program innovations and unique practice perspectives will also be accepted for publication.

Submissions

All authors should submit the original manuscript and 3 additional copies to the Editorial Director, Probe, CDHA, 1018 Merivale Rd., Suite 201, Ottawa, ON, K1Z 6A5. An acknowledgement is sent to all authors forwarding a submission. All submissions become the property of CDHA for the duration of the review process. All submissions are subject to an anonymous review by the Editorial Director and/or the Scientific Editor and at least two other referees. Acceptance or rejection of an article submitted for publication is based on editorial discretion and the referees' critiques. The author is responsible for a re-write to address the concerns of the referees. The editor reserves the right to edit the manuscripts for clarity, conciseness and adherence to Probe style requirements. Once the manuscript is slated for publication, the author will receive a copy of the edited manuscript for approval prior to publication. If the author does not respond within the given deadline, his/her acceptance of the final article is assumed.

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Titles

A brief descriptive title is preferred.

The name and professional credentials/academic degrees of each author should appear on the first page. An abbreviated title (40 characters or less) for use as a running title should be used on each consecutive page.

Illustrations

Please include visual elements where possible.

Tables: should be self-explanatory and typed on a separate page. Only essential data needed to prove a point should be tabulated. Tables should be identified with Roman numerals, eg. Table I.

Figures: Diagrams, charts, graphs and photographs are considered figures. A brief caption should be indicated on a separate sheet of paper. Figures should be identified with Arabic numbers, e.g. Fig. 1. Please ensure photographs are of high quality. Submit one set of either black and white glossy or colour photographs. Photographs are not returned unless requested. Diagrams, charts, etc. should be black and white line drawings suitable for reproduction.

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Scientific articles must provide new information, applications or theoretical developments in clinical research, treatment and prevention of oral conditions, educational studies, community health, health promotion or any other detailed investigations related to dental hygiene.

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Original research should begin with an Abstract (up to 250 words) clearly presenting the purpose, design, subjects, procedures and results of the investigation and the conclusions. The introduction should provide sufficient detail to ensure clarity, but not include data or conclusions from the study.

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Discussion

This section deals with the interpretation of the results, supported by the data. It relates observations to other relevant studies and points out the implications and limitations of the findings to dental hygiene practice. It also cites other relevant studies or conclusions that can be linked with the goals of the study. Statements and conclusions not supported by the data should be avoided.

Summary/Conclusions

This section specifies the conclusions, theoretical implications that can be drawn from the study and how these relate to dental hygiene practice and recommendations for further studies. The statements should be decisive, incisive and data centered, focussing on the highlights of the paper (200 words).

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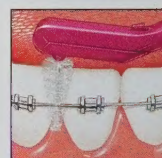
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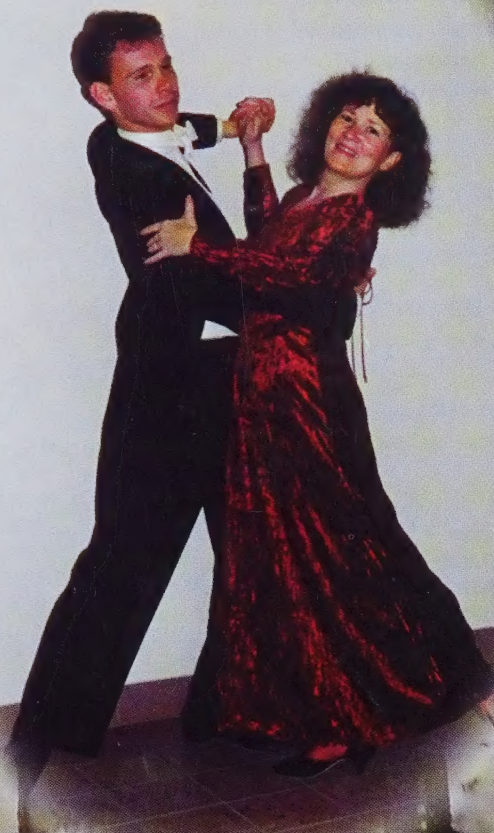
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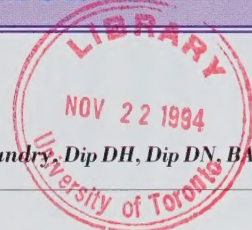
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The dentist, particularly the periodontist, uses the probe as an aid to diagnosis and treatment planning. The dental hygienist may assist the dentist in the specific measurement and charting of the periodontal pockets.

DENTAL TAPE AND FLOSS

II. USES

B. Floss for Removing

1. Gross debris and food particles

a. *At the beginning of the oral prophylaxis to facilitate proximal scaling.*

b. *In preparation for topical fluoride application.*

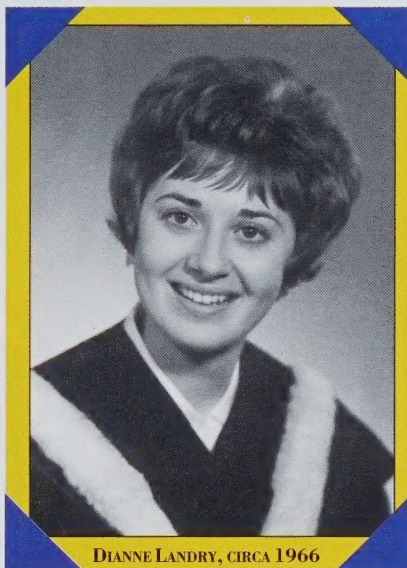
2. Particles of polishing agents at the completion of oral prophylaxis.

a. *From interproximal areas and gingival sulci.*

b. *From gingival surfaces of fixed partial dentures.*

Discussions with other "mature dental hygienists" provided startling revelations about their dental hygiene education; "I never took the periodontal probe out of its little plastic sleeve all year"; "we only flossed to get all the grit (pumice) out from between the teeth after polishing to make the patient more comfortable".

Okay! okay! What's the point here for this walk down memory lane? **The fact that there have been significant advances in both dental hygiene theory and methodologies over the past thirty years.** But has our dental hygiene practice really changed?



The 1994, 7th Edition Wilkins says:

As a primary care preventive professional, the dental hygienist is a change agent with opportunities to influence the attitudes toward, and habits of, the personal oral health of many individuals. For the clinical phases of practice, the responsibilities are to assess the patient's needs, to determine a dental hygiene diagnosis and treatment plan, to implement procedures to obtain predictable outcomes of treatment, and to evaluate the results for long term continuing supervision and replacement care.

How many of us are still leaving the periodontal probe on the tray setup during the appointment, or just flossing the client's teeth after a selective polish?

We are creatures of habit. We tend to repeat those behaviour patterns that are comfortable. I know I can get this much done in 30 minutes. The patients/clients don't want to know about flossing because I have told them twenty times already and they are still not flossing! And some of us practise from the "dead body theory", no one has died from it yet (*your* actions or lack of), so why worry about it.

We choose behaviour patterns that are based on the knowledge, skills, beliefs, values and attitudes we learned during our early life experiences, when this novel idea was being presented to us. What a tremendously significant and critical responsibility

is placed on the shoulders of our dental hygiene educators! The dental hygiene curriculum and individual program content are of tantamount importance, if we are to prepare adequately the dental hygienist for their new roles and practices influenced by the coming changes in the health-care industry.

It is never too late to learn and adapt. New beliefs, values, attitudes and skills, whether it be those of society at large, or of our profession, can be incorporated, almost painlessly, into your daily practice. The colour of the cover of this new edition registered on my recently installed political correctness barometer...pink, why pink? The inside of the book, however, speaks volumes.

Self-regulating dental hygienists must assume personal responsibility to ensure quality of care in their practices. It is your professional responsibility to continuously educate yourself. Update your knowledge and skills, not because your licensing body decrees it, but because you do not want any "dead bodies".

Then, just when you think you understand all of the rules and responsibilities attached to self-regulation, along comes another one, quality assurance. How will we know for certain that every dental hygienist is practising safely and in the client's best interests? By legislating their behaviour, through mandatory continuing education, by providing practice standards, liability insurance or on-site office inspections? These actions may work for some of the people, some of the time, but.....

As I said before, we are creatures of habit, the desire to continuously provide quality oral health care must be internalized by each individual dental hygienist. To aid this process, this concept must be incorporated into dental hygiene curriculums and transmitted to students by their educators. Life-long learning is a "need to know" not just a "nice to know". We expert hygienists also have a responsibility to act as role models for the novice hygienists. We must pay attention to our own continuous learning so as to provide individualized, quality client care, and never lose our enthusiasm and respect for our profession. 

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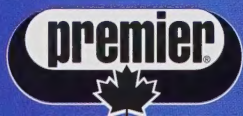
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COVER

This issue's cover features Dianne Gallagher, a graduate of the University of Manitoba's School of Dental Hygiene. Dianne received a Masters of Education from the University of Regina in 1992. She has been working in education since 1975. She is a CDHA Life Member and Past President. She is also the current Chair of the National Dental Hygiene Certification Board (NDHCB).

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L'Association Canadienne des Hygiénistes Dentaires

PROBE NOVEMBER/DECEMBER 1994 NOVEMBRE/DÉCEMBRE

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Looking for a way to enhance patient compliance?

Here's an inside tip.

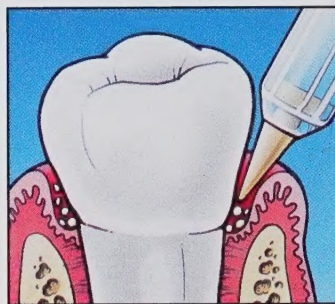
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Getting patients to comply isn't always easy. After all, you can only do so much chairside education in an office visit. But you *can* help patients do their part at home. By recommending a Water Pik® Oral Irrigator—with two types of irrigation tips.

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The Evaluation Process

It doesn't matter where you turn you see signs announcing "new and improved" (take a toothpaste display for instance!) or "changing locations to serve you better" (CDHA Central Office — another fine example) or we hear about systems being "reformed" (provincial health care systems for example). We are led to believe this is a time of change, a time of transition. Is it? Or is it business as usual? Change is what we should expect, without change there can be no improvements, without change there is stagnation.

Although we would expect, and even welcome change, we must also be devoted to ensuring change is for the better. One way of ensuring change is going in the right direction is to steer it with evaluation.

Dental hygiene practice is a process that includes assessing the information, planning the care/strategy, implementing the treatment/projects, and evaluating the outcome. Dental hygiene practice is like a continuous chain of events, dependent on the integrity of each link to ensure overall success. Although all of the links are of equal importance, if I had to pick the most susceptible one, the one most difficult to ensure, the evaluation process would get my vote. Likewise, if I had to choose the one most significant to long-term success, again, I would choose the evaluation phase. Unfortunately, evaluation is often viewed as an anti-climatic event, an afterthought, or even a threat. Keep in mind that the evaluation process determines failures as well as successes.

Perhaps if we will change our perception of evaluation we can improve our commitment to it. It is best if we see it, not only as a necessity or responsibility, but also as a benefit. As a profession, it is certainly our collective and individual responsibility to evaluate the services we provide. Treatments and procedures of dubious value should be exposed by us, not ignored until discovered by others. Changes to dental hygiene practice should come from us, not be thrust upon us.

A few recent events have prompted this message regarding evaluation. More and more the medical community is being criticized for prescribing and ordering too many costly and unnecessary procedures. They are



**MAXINE BOROWKO,
DIP DH, DIP DT, CERT VIT ED**

accused of conducting tests and treatments that haven't been evaluated or proven beneficial, with the public bearing significant human and monetary costs. Each time I hear these claims, I can't help but wonder how much we (as dental hygienists) may be costing the system by providing procedures more as a matter of routine than out of necessity, the rubber cup polish and six-month recall, to name two.

Another aspect of my life that constantly gives rise to thoughts of evaluation is my involvement with CDHA. Projects initiated by CDHA follow a process similar to that utilized by the profession in its administration of oral health care, that of assessment, planning, implementation and evaluation. There is much we, as an organized profession, can do to advance oral health and dental hygiene practice in Canada. However, we must not only continually evaluate the projects underway, but also evaluate the projects being proposed, to determine which ones to implement and which ones to put on hold, given our limited human and monetary resources.

Each council, group, or individual working on behalf of CDHA is responsible for evaluating the process used to implement their projects and the outcome. Then all projects undertaken are subjected to the scrutiny of the CDHA Board of Directors. The Board

members endeavour to ensure your resources are well utilized depending on an evaluation process to achieve this objective. Without an evaluation process it would be difficult for your Directors to be accountable to you, which, in itself, is a significant responsibility.

In my current employment situation, working in a new public dental health program, evaluation is a major topic of discussion. The program is almost two years old, and the services provided and the data collected are sufficient for reflection and evaluation. There is much to be gained through this process, not only in terms of improving our existing program but as well as promoting the development of similar programs to serve other special client groups.

In Alberta, the Health Workforce Rebalancing Committee, has been established "to overcome any existing barriers to an efficient, flexible and responsive workforce". In a joint press release, Mr. S. Day, Alberta's Minister of Labour and Ms. S. McClellan, Minister of Health, stated, "It is especially important that we look at situations where providing a health service is now the sole responsibility of one group, where there may be other competent professionals available to meet Albertan's needs."

In Alberta, consultation with stakeholders and the public are planned because numerous groups have expressed a desire for more flexibility and choice in choosing professional health services. Alberta's Health Workforce Rebalancing Committee will, no doubt, be *evaluating* a great deal of information, opinions and evidence. This will be an interesting evaluation process for dental hygienists to observe. It will also provide an excellent opportunity for dental hygienists to participate in an important process. The Alberta Dental Hygienists Association has expressed its support of the review and a willingness to contribute. The conclusions reached in Alberta will, in some way, affect dental hygienists across the country.

Regardless of what motivates change, one thing we *can* take for granted is that change is *inevitable*. What we *can't* take for granted is that it will be based on sound evaluation processes — that takes deliberate effort.





Still Celebrating!!

I was very impressed with CDHA's 25th Anniversary (celebrated five years ago)! At that time I talked with patients about the achievements and accomplishments we had witnessed in preventive oral health over the past quarter century.

Our University of Toronto Dental Hygiene class's 25th reunion was held in 1991. Two years later I celebrated 25 years of varied clinical practice in British Columbia, including 15 years of using local anaesthesia, a very progressive decision made by the College of Dental Surgeons of British Columbia. Part of my "ceremony" was to take the Current Issues in Dental Health Science course, part of the new Bachelor of Dental Science (Dental Hygiene Degree Completion Program) offered by the University of British Columbia. (Something to celebrate in itself!!)

I thought I'd be embarrassed to have an "old" certificate on the wall in the office. Au contraire! I'm proud when people comment about the date. What has kept me "at the orifice"? The three main factors seem to be: ultrasonics, periodontal probing and the people — the privilege of serving them so intimately and the reward of seeing them heal.

It's hard to believe that CDHA's 30th is already here! I was there in Saskatoon in June "for the party". Following the research theme at our conference in Niagara Falls the previous October, ethics was another welcome and challenging topic for our fifth of these annual events. I would like to commit to our profession by attending all of our Association's future national meetings. See you in Halifax next June? Also in 1994, we dental hygienists in BC are celebrating self-regulation through the new BC College of Dental Hygienists, joining the majority across Canada!

New books on my shelves include Mosby's "Comprehensive Review of Dental Hygiene" (Darby, 3rd edition) and "Comprehensive Dental Hygiene Care", (4th edition by our dear Irene Woodall — how I hope her health is improving.) Both are 1993 publications. Dr. Esther Wilkins' 7th edition of "The Clinical Practice of the Dental Hygienist" (1994) is also now available. It has been a very good year for updating!

I would like to suggest that, to keep current and to celebrate your career, you purchase the above listed "holy books". It takes three years for information to get into these texts. Read our professional journal and learn how

to critically evaluate what you read. (See the article about that by McCann and Schneiderman in the April 1994 issue of Explorer.) Form a Study Club with speakers or literature reviews, or for "hands on" learning, organize a group to take the "Taking Steps to Ensure Quality Dental Hygiene Care" workshop (a revised edition soon to be available through CDHA). The peer contact and support network will be invaluable.

Consider the new toothbrush designs. More people are keeping "longer teeth longer". Needs are changing and dental hygienists are well-qualified to advise manufacturers. Can we "outlaw" hard toothbrushes? Let's continue to make a difference. We can do this best through our united organization. If you haven't been active in your local Dental Hygiene Society — look them up! Volunteer. Come to meetings. Plan holidays around conferences. Be part of our maturing profession as our specific body of knowledge grows and changes.

Yours in "celebration",

**Franci Louann (Workman), RDH
(U of T, '66)**

I wish to express my sincere appreciation to CDHA and AquaFresh for the honour of receiving the AquaFresh Student Hygienists Scholarship. I was especially impressed by the professional and dedicated dental hygienists I met at the CDHA Conference held in Saskatoon. The opportunity to meet colleagues from coast to coast was an invaluable experience. They instilled in me, feelings of fellowship, enthusiasm and pride in my chosen profession. What a wonderful way to begin a new career!

Dorothy Cairns

Dear Editor:

I recently had a lively discussion with my three dental hygienist co-workers regarding our national Journal, *Probe*. We specifically discussed the use of a personal photograph on the cover.

Half of us liked the informality of this idea because it brought the human and personal aspect to our profession. It emphasizes that we are not one dimensional and that our professional lives must be balanced with our private lives.

Others felt that even though *Probe* contains valuable scientific information — that fact is not apparent from the cover at all. The use of personal photographs may not convey the professional image that we wish to portray.

Some suggestions for the cover were:

- print the personal profile and photograph inside the issue instead of on the cover;
- continue putting the personal photograph on the cover, but make the photograph separate from the name of the Journal (the *Probe* title gets lost in the photograph);
- on the cover, indicate the scientific articles and the feature article so it can be seen at a glance (somewhat like Macleans).

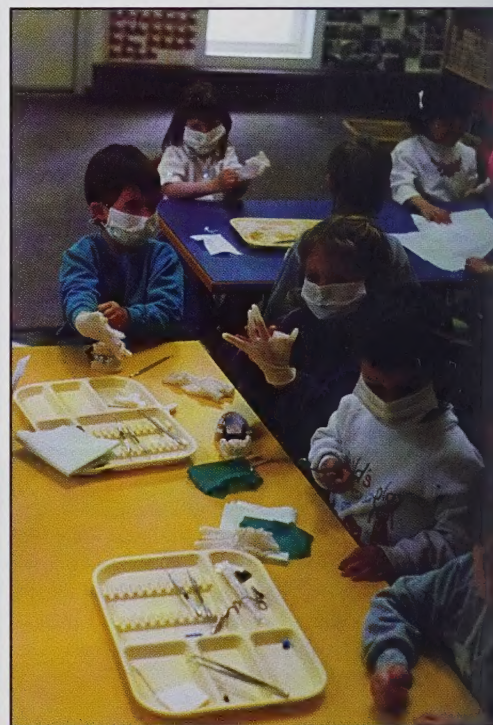
We hope our comments and suggestions are of some help.

Sincerely,

**Holly Wilson, Dorothy Cairns,
Shirley Woods, Shirley Bassett
Community Dental Hygienists**

CDHA welcomes your comments and/or suggestions regarding issues raised in *Probe* or affecting the Dental Hygiene Profession.

Send your letters to CDHA, *Probe* Managing Editor, 96 Centrepoin Drive, Nepean (Ottawa) ON K2G 6B1.



Since 1981, Pennie Casey a CDHA member residing in Canmore, Alberta, has been making an annual visit to the 4-year olds at the Canmore Preschool. The purpose of her visit is to introduce the pre-schoolers to materials and equipment used in dentistry.

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NEWS


The Canadian Dental
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Your Professional Partner

Canadian Dental Hygiene Researchers Invited to Join New Dental Hygiene Research Group

CDHA's junior International Federation of Dental Hygienists representative, Ellen Brownstone, says that by joining the International Association for Dental Research (IADR) Oral/Dental Hygiene Research Group Canadian dental hygienists will help contribute to dental hygiene's professionalization and growth. Ms. Brownstone says the creation of this group presents a wonderful opportunity for dental hygienists to present their research at an international forum and will also give dental hygienists an opportunity to collaborate and network with other researchers outside of the discipline of dental hygiene.

The proposal to form a Dental Hygiene Research Group within IADR was developed

by the International Federation of Dental Hygienists (IFDH) and in August 1994 it was approved. IADR's Oral/Dental Hygiene Research Group is open to all individuals who are interested in research related to oral hygiene and its impact on oral health status, as well as to those interested in dental hygiene research.

Subject areas for review of abstracts cover a broad array of basic, clinical and applied studies related to: oral/dental hygiene strategies for the outcomes of primary and secondary preventive care provided to, and in collaboration with, individuals and groups in a variety of settings; interdisciplinary approaches to integrating oral health into general health; clinical efficacy of profes-

sional and personal oral hygiene measures; methods to improve health outcomes of compromised patients through improved oral hygiene; the dental hygiene process of care; self-care strategies including adaptations for special and culturally diverse populations, client coping and practitioner caring dimensions, promotion of healthy lifestyles; disease prevention/health promotion focused curricula models; science transfer methods; ethics and quality assurance; alternative patterns of practice; clinical decision-making; and issues related to the conduct of research including approaches to subject recruitment and retention, protocol compliance, data management and monitoring, quality control, and study coordination.

CALL FOR APPLICANTS CDHA Dental Hygiene Research Grant

Objective: To support Canadian Dental Hygienists engaged in research that enhances the dental hygiene profession's ability to promote health and well-being.

General Description: A grant of \$5,000 will be awarded annually to a Canadian Dental Hygienist involved in qualitative or quantitative research as a principal investigator or co-investigator. Preference will be given to research projects relevant to the discipline of dental hygiene and the goals of the CDHA.

Eligibility: Applicants for this grant must be academically qualified Canadian Dental Hygienists who are active or life CDHA members in good standing. Evidence of academic credentials at the Masters and/or PhD level is required.

Applications: The deadline is March 31, 1995. Applications must be submitted on forms available from CDHA's Central Office.

Condition of Award: On completion of the research project, recipients of this grant agree to provide a written report for the Probe or reprints of journal articles to CDHA's Central Office.

For further information and/or an application form contact:

Canadian Dental Hygienists Association
CentrepoinTE Chambers
96 CentrepoinTE Drive
Nepean (Ottawa), ON K2G 6B1

Two CDHA Members Working to Develop Smoking Cessation Program for Ontario's York Region

CDHA members Cheryl Cancelli and Nancy Orschel are two of eight members on Heart Action's Committee to Introduce A Smoking Cessation Program to Ontario's York Region. Heart Action is an Ontario government organization created to help foster community health programs for healthy hearts. The committee is chaired by a Heart Action representative and other committee members include two dentists from the York Region (including the Dental Director of York Region's Public Health Unit), a psychologist, a nutritionist, and a representative of York Region's Public Health. Ms. Cancelli came up with the name for the committee's information package, "Light Up Your Smile — Quit Smoking" that is to be distributed in the York region.

CALL FOR APPLICANTS



/ *Procter & Gamble Inc.*

Graduate Student Research Award

Objective: To promote the research training of Canadian dental hygienists in research oriented Masters or Doctoral programs.

General Description: An award of \$5,000 will be given annually to a highly qualified candidate enrolled as a graduate student in a Masters or Doctoral program.

Eligibility: Applicants for this award must be Canadian Dental Hygienists who are active, associate, student or life CDHA members, in good standing, who may be studying full or part time. Applicants must present evidence of having been accepted by a recognized academic institution.

Applications: The deadline is April 1, 1995. Applications must be submitted on forms available from CDHA's Central Office.

Duration: This award is made for one academic year for full-time students or the equivalent for part-time students. The award may be renewable for one additional academic year or its equivalent on receipt of a satisfactory progress report. The progress report must detail work to date and include any pre-prints or reprints arising from the work. Any request for renewal of this award should be accompanied by a letter from the research supervisor and one other referee.

Condition of Support: On completion of studies, recipients of this award agree to provide a bound copy of the thesis or project to CDHA's Central Office.

For further information and application forms contact:

Canadian Dental Hygienists Association
Centrepointe Chambers
96 Centrepointe Dr.
Nepean (Ottawa), ON K2G 6B1

British Columbia Institute of Technology Awarded Degree Granting Status

In May, the British Columbia Institute of Technology (BCIT) was awarded degree granting status. Formerly, BCIT worked in conjunction with BC's Open Learning University to provide degree completion opportunities in the health science fields. BCIT will continue to work with BC's Open Learning University for some programs in addition to offering its own program for others.

Now that it has degree granting status, there are plans to proceed with a number of different baccalaureate programs including one for critical care nursing and another in environmental health studies.

BCIT is also considering the development of a baccalaureate in Health Care Management. This proposed two-year degree completion program would focus on such courses as health policy, health care delivery systems, organizational structures, communications and teamwork concepts. Several of the programs offered would be accessible through distance learning strategies, but may also include compressed on-site experiences, depending on the nature of the program developed. Dental hygienists graduating from a two-year diploma program may be eligible for the baccalaureate program in health care management.

If you are interested in tracking the progress of the implementation of these degree completion programs, contact the BCIT Health Part Time Studies at (604) 439-4100.

In Memoriam Barbara Jean Ferris



Barbara Jean Ferris passed away peacefully July 21, 1994 after a courageous battle with leukemia. She graduated from the University of Manitoba, School of Dental Hygiene in 1970. Barb received a Bachelor of Arts Degree and Certificate in Business Administration from the University of Saskatchewan.

Her dental hygiene career spanned private practice, public health and dental assisting and dental hygiene education. Her real love was teaching. She taught Dental Assisting at Red River Community College in Winnipeg,

Kelsey College in Saskatoon, Wascana Institute in Regina and Vancouver Community College. Barb taught dental science and dental radiography at Camosun College Dental Hygiene Program. She was a dedicated, knowledgeable teacher who established a special rapport with her students and was well respected by her colleagues.

Barb touched many people with her caring ways and wonderful sense of humour. She will be greatly missed by family, friends and students.

A scholarship fund has been established in Barb's name at Camosun College. Donations to the "Barbara Ferris Memorial Scholarship for Dental Hygiene Students", care of Camosun College Foundation, 3100 Foul Bay Road, Victoria, BC, V8P 5J2, will be gratefully accepted.





Dentistry Canada Fund Up and Running

On May 3, 1994 the Ministry of Industry Science, by issuing supplementary letters patent, completed the merger of the Canadian Fund for Dental Education (CFDE), the Canadian Dental Foundation, the Grieve Memorial Lectureship Trust, the Canadian Dental Research Fund and the Library Trust Fund. The resultant Dentistry Canada Fund (DCF), which encompasses the mandate of all of the aforementioned organizations, has the following objectives:

- (a) To create and operate a fund for the citizens of Canada to assist in the encouragement of optimal oral health in Canada, through education, research and promotion.
- (b) To encourage the highest level of competence among Canadian dentists through the support of public research, lectures, seminars and other similar programs.
- (c) To assist in the growth, development and advancement of dental education and the elevation of the qualification of teaching personnel through teaching and management programs and lectures.
- (d) To assist meritorious and/or needy students by means of awards and fellowships through public advertisement and juried review panels as funds permit.
- (e) To support and maintain the Sydney Wood Bradley Memorial Library as a source and repository for material and data for research into the conduct of the practice of dentistry.

- (f) To cooperate, assist and collaborate with other dental professional and dental industry organizations concerned with oral health care. Any such organizations receiving funds from the Dentistry Canada Fund must be qualified donees as the term is defined in the *Income Tax Act of Canada*.
- (g) To conduct educational programs for the public about the importance of optimal oral health and the means to attain and preserve it.
- (h) To solicit, receive and hold donations, gifts, devises and bequests for the objects of the corporation.
- (i) To utilize and distribute such money and property in the furtherance of the objects of the corporation.

The Canadian Fund for Dental Education (now part of the Dentistry Canada Fund (DCF)) had a long tradition of supporting the work of Canadian dental hygienists: since 1989 CFDE granted nearly \$30,000 for Hygiene Fellowships, in 1993, \$6,000 was awarded to help fund the CDHA North American Research Conference, and \$2,000 per annum is made available to the ODHA for Educational Projects thanks to the generosity of Warner-Lambert Inc.

In March 1994, Louanne Keenan was awarded a \$3,000 CFDE Fellowship for the Master of Adult and Higher Education Program at the University of Alberta. This year's



Louanne Keenan

Noble received the \$2,500 CFDE/Warner Lambert Hygiene Teachers Fellowship. A \$10,000 grant was also awarded under the Dentistry Canada Fund to support the recent Dental Hygiene Educational Standards Workshop that was held in Winnipeg, October 28 & 29.

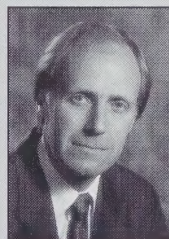
DCF Fellowship application forms are available by contacting James Wegg, DCF Manager, 1815 Alta Vista Dr., Ottawa, ON, K1G 3Y6, (613) 731-0493.

The Canadian Dental Hygienists Association has its own Developing Fund under the new DCF umbrella and members are encouraged to donate to the profession through this avenue. Once CDHA's Development Fund surpasses \$10,000 it will automatically become an endowment fund and the interest it generates will provide additional support for dental hygienists in Canada.



Canadian Dental Association Elects New President

Dr. Bryn Sigfstead of Edmonton, Alberta became President of the Canadian Dental Association (CDA) at its Annual Meeting held in October, in conjunction with the FDI Congress which was hosted by the CDA this year in Vancouver.



engaged in private practice (orthodontics) in Edmonton.

Dr. Sigfstead has been a member of CDA's Executive Council since 1987 and served as President of the Alberta Dental Association from 1984-85. He has also served as President of the Western Canada Orthodontic Society (1978-79), the Alberta Orthodontic Society (1978-79) and the Edmonton District Dental Society (1977-78). He is a father of three sons and enjoys skiing, squash, sailing, cycling and curling.

Dr. Sigfstead was born in Rose Valley, Saskatchewan and received his DDS in 1967 from the University of Alberta. In 1973 he earned an Orthodontic Diploma at the University of Alberta and is currently



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Convocation Address delivered by Marnie Forgay to 1994 Graduates of Dalhousie University's Faculties of Dentistry and Medicine

Mr. Chancellor, Mr. President, honoured guests, members of the graduating class of 1994, families, friends:

There is something very special about a Dalhousie Convocation.

All convocations share certain agreeable characteristics:

They provide a formal opportunity, complete with some remnant of medieval pageantry, to honour those who have earned the diplomas and degrees bestowed upon them; to celebrate their achievements, and to wish them success in their chosen fields.

For families and close friends, the importance of the event has no equal: There are likely few moments as proud as when that particular graduate proceeds across the platform to receive his or her diploma or degree, for which everyone has worked so hard.

Like many others who have made their careers mostly in the academic world, I have attended more convocations than I can remember. They are all impressive, but as I said earlier, Dalhousie Convocations are special. This is certainly, in part, because of the long tradition and reputation for excellence of this University. This reputation reflects the qualities of its faculty, its leaders, its students, its alumni. Every Dalhousie graduate is proud to be known as one. I am grateful today to join those ranks, and thank the University for this honour. I feel a bit overwhelmed, but perhaps, unfortunately, not quite speechless.

The size and nature of Dalhousie convocation ceremonies are also special: a marvelous combination of ceremony and informality. Although it is expensive and logistically difficult to hold several separate ceremonies each year, the very human scale of these events permits a feeling of closeness among those present - indeed a feeling of 'family' which is an extension of the close relationships developed in relatively small faculties during the preceding years.

We are here to honour those who have successfully completed their studies in dental hygiene, dentistry and medicine. It is natural that they see today as a landmark in their lives, and an opportunity to look back over their years of studies.

I had an opportunity to speak with a few of the graduates, and members of all three groups told me that they feel well-prepared for the next stage of their careers, whether it is in a residency program or entering practice. They speak highly of their education, the expertise, interest and concern of their professors and other university staff members, and especially of the close friendships that have been firmly woven with their classmates. They feel these will last a lifetime and they are right. The graduating students are also very aware and appreciative of the help and support of their parents, partners, children, and friends which has enabled them to be here today.

As appropriate as it is to look back on this occasion, Convocation is also an opportunity to look forward. The graduates that I was able to speak with, know very well that they are facing uncertain and probably difficult times. Hard economic times and radical changes proposed in health care delivery concern them. All three professions are in a period of rapid change.

We are better prepared to manage and adjust to changes that face us if we can discern some of the trends that underlie and shape those changes.

Not long ago, the Pew Health Professions Commission in the United States reported the results of its examination of trends shaping health care, and the characteristics and competencies that will be necessary for health care practitioners in the year 2005.

It pays to be cautious in applying comments from the United States to the Canadian scene. There are many differences between the two countries, and some of these relate to societal attitudes toward health care. In Canada, basic medical care is widely regarded as a resource which should be accessible to all; in the United States, at least until recently, it has been regarded as a commodity, to be purchased like any other by those who can afford it, and perhaps also provided in some measure to the least fortunate in society.

Parenthetically, it is unfortunate, at least in the view of many of us, that that attitude has been the way oral health has been regarded in Canada. Although we profess the belief that oral health is integral and necessary to overall health, we still have a long way to go to implement that belief.

In spite of reservations about cross-border comparisons, it is clear that at least some of the trends in the United States reported by the Pew Commission are evidenced here as well. One of these trends is increasing tension related to the rapid expansion of science and technology. Our health care system is a reflection of societal values. Sometimes, however, these values are contradictory. We value the benefits from therapeutic and diagnostic improvements brought about through technology, but we must increasingly make tough choices about how we will deploy our limited resources, balancing technological sophistication against other values which emphasize the quality of life. Increasing reliance on more and more complex technology depersonalizes and fragments care. We must acknowledge that issues such as the manage-

ment of patient information, artificial extension of life span, genetic engineering, and advances in reproductive technology are problems for us all. They are too important to be left to the law makers and scientists, or any select few, since they speak fundamentally to the very nature of our society and its values. Increasingly, society will demand that technological advances will have to fit into a balanced and integrated approach to health care.

In looking to demographic trends, we can see that our population is both aging and becoming more diverse. Older people are not only increasing in numbers, but as a proportion of the total population. This will produce profound changes in the nature of demands for health care. In oral health, for example, the age shift, combined with changes in the epidemiology of dental disease, is resulting in a large group of older persons whose needs are primarily for disease prevention and health maintenance — a drastic change from a generation ago.

Another change is the shift in focus from acute to chronic health problems. The 'new elderly' will differ from seniors in past generations. They will be better educated, more financially secure, more politically active and powerful and have higher expectations of health care systems and providers.

Ethnic diversity in Canada is also increasing. This is resulting in a different mix of problems among our client groups, a need to understand different cultural values and health-related practices, and a need to ensure that our education system produces professions whose compositions are a better reflection of the populations they serve.

Another trend is for improved efficiency and effectiveness in health care. The need to contain costs will result in more attention to overall health of the population, with emphasis on primary care and prevention. This must lead to better coordinated care. I hope it will also lead to a better integration of oral health into overall health concerns. We must explore a different 'mix' of health care providers, and different, lower-cost settings for care.

A fourth trend is that of consumer empowerment. There are new relationships emerging between health care providers and those whom we serve. Informed consent, quality assurance, and accountability are but three areas where consumers of health care services are demonstrating growing expectations. Consumers are beginning to emphasize an interest in health and wellness, as contrasted to just the diagnosis and treatment of disease. And they want access to a broader range of providers.

When facing these changes, we need to understand that not only will we have to embrace new ideas, goals and ways of doing things, but, much more difficult, we will have to shed many firmly held assumptions. Many of these assumptions are implicit, rather than explicit, and have been acquired as part of our socialization into our chosen professions.

What characteristics will be needed to cope appropriately with these trends? Some fundamental competencies, essential to all those who will be providing health care early in the coming century, have been identified. They can be grouped into four areas:

A number of competencies focus on the community and its health-related values. These include:

- caring for the community's health;
- ensuring cost-effective and appropriate care, and
- expanding access to effective care;
- improving the health care system.

A second cluster of characteristics centres around health promotion and the recognition of clients as partners in health care. These include:

- emphasizing primary care;
- promoting healthy lifestyles;
- accommodating expanded accountability.
- practicing prevention;
- understanding of the role of the physical environment, and

As well, health care providers will need to be able to:

- access technology properly;
- provide contemporary clinical care.
- manage information, and

The final and most fundamental necessary characteristic is *continuous learning*. In the next five years, those who graduate today will learn at least as much about their discipline as they have up to this point. These years will see their transition from being 'safe beginners' to begin residencies or practice, to proficiency, displaying a much broader range of understanding, integration, and skill. Understanding the necessity to continue learning throughout their professional lives must be firmly ingrained. Practitioners without this characteristic are not just outdated, they are a danger to their clients and themselves.

All of us have confidence that those graduating today will meet well the challenges they face. We congratulate them, and send them forward with our best wishes and continued support. Thank you.



The Efficacy of Electric-Powered Toothbrushes: A Literature Review

L'efficacité des brosses à dents électriques: Revue de la documentation

By/par:
Marie Lochhead, Dip DH

Preface

This literature review considers several studies on the use and efficacy of electric-powered toothbrushes. The review is intended to help the reader evaluate the credibility and validity of studies investigating manual and electric-powered toothbrushes. Various factors influence the outcome of studies on electric-powered brushes. These factors include: the length of the study, efficacy of removing supragingival and subgingival plaque, abrasion, effects on periodontal disease, duration of toothbrushing, instructions given, professional prophylaxis prior to and during study, and indices used.

Introduction

Mechanical tooth cleaning still remains the most reliable method of controlling supragingival bacterial plaque. Failure to achieve adequate plaque control and lack of technical skill of the client lessen the effectiveness of conventional toothbrushing.^{6,1} Some studies indicate that electric toothbrushes are superior to manual ones in terms of removing plaque and improving gingival health. Several other studies, however, conclude that conventional (manual) brushes and electric brushes are equally effective. Other studies also indicate that electric-powered toothbrushes with brush heads similar to manual toothbrushes usually show a novelty effect, in that, plaque removal efficiency improves for only a short time.² Killoy and coworkers note in their study that both conventional and electric brushes significantly decreased plaque at all time intervals. Counter-rotary brushes are indicated for those clients whose best efforts with conventional brushing cannot achieve desired levels of plaque reduction.⁶ In general, studies indicate that electric-powered toothbrushes perform either as well as manual brushes, or are more effective on interproximal surfaces. However, some electric-powered brushes are shown to be ineffective in removing plaque on lingual and palatal areas. Therefore, when determining the efficacy of the brushes, all tooth surface areas and study variables should be taken into consideration.



MARIE LOCHHEAD, DIP DH

Préface

Ce document examine plusieurs études portant sur l'utilisation des brosses à dents électriques et leur efficacité. Il a pour objet d'aider les lecteurs à évaluer la qualité des études qui comparent les brosses électriques aux manuelles. Divers facteurs ont influencé les études, l'efficacité de la brosse pour enlever la plaque supragingivale et sousgingivale, l'abrasion, les effets sur les maladies parodontales, la durée du brossage, les directives du départ, la prophylaxie professionnelle avant et pendant l'étude, ainsi que les indices employés.

Introduction

La brosse à dents électrique demeure toujours le moyen le plus efficace de contrôler la plaque supragingivale et on trouve la brosse à dents classique moins efficace, à cause de l'insuffisance du contrôle de la plaque et du manque d'habileté technique du client^{6,1}. Certaines études indiquent que les brosses à dents électriques sont supérieures aux brosses manuelles pour enlever la plaque et améliorer la santé des gencives. Plusieurs autres études concluent, cependant, que les deux types de brosses sont aussi efficaces l'un que l'autre. Si certaines études relèvent que les brosses électriques munies d'une tête semblable à celle des brosses manuelles ont un effet de nouveauté, en ce sens qu'elles améliorent le contrôle de la plaque mais pour un temps seulement², d'autres ne l'indiquent pas⁶. Killoy et ses collègues ont remarqué dans leur étude que toutes deux, la brosse classique et la brosse électrique, permettaient de réduire la plaque à tous les intervalles. On a recommandé des brosses à mouvement de rotation alternée à des clients qui, malgré tous leurs efforts, n'arrivaient pas à enlever la plaque en quantité souhaitable⁶. Les études indiquent en général que les brosses à dents électriques sont soit aussi efficaces que les manuelles, soit plus efficaces sur les faces interproximales. Pourtant, certaines d'entre elles se sont avérées inefficaces pour enlever la plaque dans les zones linguales et palatales. Il faut donc considérer les faces de toutes les zones pour établir l'efficacité des brosses à dents.

Length of Studies

Most of the studies were conducted over a twenty-eight day period, a relatively short period of time to consider the use of a "new" brush in conjunction with the subjects accuracy to remove plaque.^{1,2,3,4,6} Baab and Johnson's telephone survey conducted six months later confirmed that most subjects were no longer using the device (electric brush) twice daily as they had done in the study.² The novelty effect had worn off. Clients seemed to revert to past oral hygiene habits when the study is over, also a common problem with mechanical plaque control devices.² Boyd and coworkers followed their subjects for a twelve month study on their periodontal status with the use of a rotary electric toothbrush vs. a manual during periodontal maintenance phase.³ This study indicated the electric-powered toothbrush was as effective in plaque removal as the conventional (manual) toothbrush.

Indices Used

Indices used by investigators are not all the same. Boyd and coworkers evaluated the electric-powered and manual toothbrush by evaluating the subjects on plaque accumulation, gingival index, pocket depth, loss of attachment and microbiological changes.³ Khocht, Boyd and Van der Weijden used the Silness-Loe plaque index. Baab utilized the O'Leary plaque control record, Killoy used Modified O'Leary & Turesky plaque index and Barnett & Muhleman bleeding index.

"Electric brushes were shown to be more effective in interproximal areas."

Duration of Toothbrushing

Van Der Weijden and coworkers were the only researchers that dealt with effectiveness of plaque removal in relation to toothbrushing duration.⁵ Brushing for 30 seconds or more per quadrant with all four brushes (3 electric type and 1 manual) removed about 90% of the plaque from the vestibular and lingual surfaces. Evaluation of brushing time showed that for all brushes the greatest effect was reached after 30 seconds of brushing per quadrant. Therefore, because efficacy increases with time, brushing-time is an important variable. Until the duration of brushing is standardized, it can be debated whether it is equitable to state that one brush is as effective as the other. Electric brushes were shown to be more effective in interproximal areas. Vestibular and lingual areas were shown to be free from plaque after 90 seconds per quadrant of manual brushing.

Oral Hygiene Instructions

During Killoy and coworkers study⁶, oral hygiene instructions were given at three different time periods. In this study however, details of the hygiene instructions given to all subjects were not stated.

Khocht and coworkers had a Dental Hygienist demonstrate oral hygiene techniques to all subjects. The electric-powered toothbrush subjects were instructed according to the manufacturer's recommendations. These recommendations were not stated in the study. Subjects utilizing manual toothbrushes were shown the modified bass technique. Length of instruction time was not given. Subjects in both groups were instructed to brush until their teeth "were clean". Subjects were not required to brush for a specific amount of time. Both groups were instructed to brush twice daily.

Boyd and coworkers utilized the modified bass technique for subjects using a manual soft toothbrush. These instructions were demonstrated by a Dental Hygienist. Dental floss, toothpicks, and interdental brushes were to be used once a day by all subjects in the manual toothbrush group. Subjects in the rotary toothbrush group were instructed to use only that brush for all plaque removal and not to use any additional oral hygiene aids. Initial instructions for both groups was 30 minutes in length. Follow up reinforcing sessions were 10-15 minutes in length. All subjects were to brush twice daily.

Baab and coworkers also used the modified bass technique in the manual toothbrush group. Subjects were instructed chairside by a Dental Hygienist. Subjects receiving an electric brush were instructed to apply the bristles perpendicular to the teeth, concentrating on the gingival sulcus. All subjects were to brush twice daily for a time period of three minutes. Length of chairside instructions were not given.

Professional Prophylaxis Prior to and During Study

Baab and coworkers as well as Killoy, did not state the frequency of a professional prophylaxis experienced by the subjects used in their study.^{2,6} Boyd and coworkers drew on clients who had received periodontal treatment, including surgery, in the year prior to the study, from a postdoctoral periodontal clinic. One week prior to the study, the subjects had a one hour professional periodontal maintenance appointment which included subgingival debridement. This, as well as monitoring of the periodontal status for attachment loss, was repeated at 6 and 12 month intervals.³ Murray also chose subjects who had previously received periodontal treatment and who were currently on a 3 month periodontal maintenance program.⁴ Van der Weijden, however, used dental students and junior staff of the periodontal department.⁵ His study consisted of a single prophylaxis followed by five timed toothbrushing durations. Prior to each session, subjects were asked to abstain from oral hygiene procedures for a least 24 hours.

Efficacy of Removing Supragingival Plaque

Baab and coworkers compared two electric-powered toothbrushes and a manual brush for effectiveness in removing supragingival plaque and resolving gingivitis.² Subjects using electric-powered brushes had significantly lower mean plaque and gingival inflammation scores. Results suggested that the electric brush was better in removing supragingival plaque and in resolving gingivitis. These differences in scores were a result of the increased effectiveness of the electric brush in cleaning interproximal regions. Gingival Index (GI) scores failed, however, to demonstrate a significantly different trend between groups (electric and manual). Van der Weijden and coworkers detected that both electric and manual toothbrushes had significantly improved over all GI scores. The control group (manual brush), however, was better in achieving the lowest average plaque scores in palatal and lingual surfaces than both of the electric brush groups.⁵

Abrasion

Boyd and coworkers' twelve month study noted that no gingival abrasions were recorded for any subjects in either study group at any of the clinical examinations.³ Khocht and coworkers did not note any gingival abrasion in any of the study groups. Baab and coworkers reported that the electric brush appeared to be no more abrasive on enamel and cementum than a manual brush; no soft tissue sites were discussed.²

Microbiota & Supragingival Plaque

Murray and coworkers indicated that there was a significant shift in the microbiota of both groups (manual and electric) towards a flora associated with gingival health.⁴ Boyd also stated that a four month study conducted by Glavind and Leuner showed that, clients provided with the rotary toothbrush improved oral hygiene and gingival health to the same degree as clients who received a comprehensive oral hygiene kit (combination of manual toothbrush and interdental aids).³ Murray also states that his results proved to be similar to a study done by Kho et al and Loos et al, who reported that decreased supragingival plaque alone was not sufficient to produce significant changes.⁴ Murray further reiterates what Listgarten et al reported, that for pockets greater than five millimeters, supragingival plaque control alone had no effect on the subgingival microflora evaluated microscopically.

Discussion

Studies reviewed suffered from one or more of the following drawbacks: lack of controls, extremely short trial period, non-random assignment of treatment, lack of blind examiner and uncontrolled time periods of brushing by subjects. Other variables that the reader should take into consideration when reviewing studies include the type of indices used, the various hygiene modalities and oral hygiene adjuncts used by subjects. The possibility that subjects in the study may have made a conscious effort on their oral hygiene should also be taken into account. The participation of some subjects may have been influenced by a monetary reward offered after successfully completing the study.

Conclusion

New technology and knowledge gives birth to new inventions. It is a true test of skill and knowledge to look beyond hearsay or studies conducted by non-independent researchers. When recommending any oral hygiene devices, consideration of a client's needs must be taken into account. As Dental Hygienists and primary oral health providers, we must stay abreast of new products available to clients. There are many ways to acquire information regarding product efficacy and safety. There are various dental/medical journals to access, the opportunity to be members of our professional associations and various study groups. If you are not maintaining your professional obligation, seize the moment now!

Acknowledgments

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Marie Lochhead resides in Fort Erie, Ontario. She received her Associates in Science Degree with Honours in 1981 from Onondaga Community College, Syracuse, New York. She has practised clinically in both the United States and Canada. Marie has been a clinical periodontal hygienist for the past eleven years in private practice. She is a part-time faculty member at Niagara College in Welland, Ontario in the Dental Hygiene program. She is also the incoming President for the Niagara Dental Hygienists Component Society.



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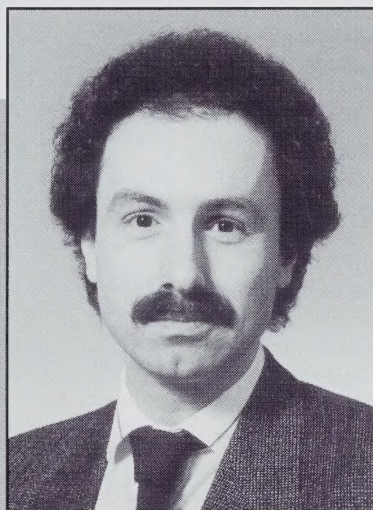
*based on a presentation by Gary Chiodo, DMD
prepared by: Dianne Landry, Dip DH, Dip DN, BA, BV/TEd*

(The following article is excerpted from the text of a presentation delivered by Gary Chiodo, DMD during the CDHA's 5th Annual Professional Conference held in Saskatoon, SK, June 17-19, 1994. Dr. Chiodo is a professor of public health dentistry at the Oregon Health Sciences University School of Dentistry. In addition, he serves as Assistant Director of the University's Center for Ethics in Health Care. He received his Certificate in Health Care Ethics from the University of Washington School of Medicine in 1992. Dr. Chiodo is currently co-editor of regular ethic columns in both the Journal of the Academy of General Dentistry and the Journal of the Oregon Dental Association.)

Practicing dental hygienists, or any other health care worker, may ethically voice their values either individually or collectively. Let us examine these two separate categories of values.

First, your individual values are related to the person you are. These values reflect your family background, your culture and ethnicity, your religion, your political affiliation, and a myriad of personal experiences, beliefs, and preferences. Second, you have been influenced by the collective values of the profession you have entered. These professional values are influenced by moral theory, codes of ethics, ethical principles, and the accepted standards of all health care professions, not just dental hygiene, but those of nursing, dentistry, medicine, social work, psychology, and others.

Out of this juxtaposition of personal and professional values, you must somehow reach a values consensus for your practice. This consensus usually reflects a merging of personal and professional values. The longer we live, the more robust or informed the personal side becomes. As we begin to encounter new situations that contain elements of previous situations, our beliefs expand and are refined about those situations. The professional side derives entirely from practice and educational experience. This side **does not** derive from personal beliefs. Health care workers are not *legally* nor *ethically* allowed that privilege. It may be concordant with personal beliefs, but that is a coincidence, not a requirement nor an expectation. In our professional lives the two sides must merge into an informed, impartial, and just mode of decision making.



GARY CHIODO, DMD

However, philosophically reasonable this may sound, when you are sitting chairside and come face-to-face with an ethical dilemma, you need some practical information to help you deal with these ethical dilemmas. How do I make this ethical decision? How do I go about weighing benefits and harms, good and bad, right and wrong, when there is uncertainty? How do I take ethics out of the seminar room and into practice? That is the essence, the spirit of *applied ethics*.

As is almost always the case in teaching health care ethics, the best way to answer these questions is to consider them with real-life cases. Cases that dental hygienists have confronted and resolved will be considered in the light of a larger body of information concerning the ethical dilemmas encountered by dental hygienists. That information comes from a 40 item questionnaire mailed to 2,251 American Dental Hygienists' Association members. I do believe that the ethical dilemmas encountered by those

dental hygienists practicing to the south of us are substantially similar to those encountered by Canadian dental hygienists. From the 1,523 responses arose 17 different ethical problems and these are published along with a complete discussion in the June 1990 issue of the Journal of Dental Hygiene.

In the process of considering the five most frequent ethical problems, I have incorporated three actual cases to make ethics real, that is, to remove these ethical dilemmas from the exclusive realm of philosophy and to place them squarely in the operatory with you sitting next to these real-life patients. These ethical dilemmas occurred either sometimes or often for over 50% of all respondents and are, therefore, frequent enough to warrant attention.

- **Observed another dental hygienist provide substandard care.**
- **Observed situations in which nondiagnosis of dental disease resulted in an overall decline in patient dental health.**

Both of these situations are ethical dilemmas for dental hygienists because they call upon you to be truly self-policing. One of the distinguishing characteristics of a profession versus a trade is that professionals are entrusted by the public, and permitted by the government, to police themselves. It is recognized by the public that what we do in health care is very complex and highly specialized. No one amongst the lay public can be expected to understand, in sufficient depth, the intricacies and particulars of what a dental hygienist, a nurse, a physical therapist, a dentist, or a cardiovascular surgeon does. Thus, those who are in these professions are expected to develop the curriculum guidelines that describe the levels of knowledge and skill required to enter those professions. Similarly, those in the professions are expected to determine what practices and outcomes meet acceptable professional standards and which fall below those standards.

When a provider is deemed to have fallen below the standards collectively determined to be minimally acceptable, the profession also must decide how that provider should be treated. Again, this process represents the true spirit and essence of applied ethics. Being a self-policing profession calls upon us to apply ethics whenever we encounter evidence that a colleague has provided substandard care or is practicing in a manner that may endanger patients. Often, in ethics-talk, we refer to this as "whistle-blowing."

Our professional obligation to serve as whistle-blowers when called to do so derives from the ethical obligations to be *beneficent* to all patients (that is, to strive with every patient encounter to benefit the patient) and to be *nonmaleficent* (that is, to strive with every patient encounter to avoid unnecessarily harming the patient). However, whistle-blowing goes beyond these obligations of provider to patient and calls upon us to police ourselves for the benefit of the entire community of patients. When we call to task the malpracticing provider, we protect not only the immediate patient who presents with evidence of improper care, but we also protect the hundreds of other patients who may encounter this provider in the future. Moreover, we bolster the community's trust in us and in the profession when individuals see that we do not always protect each other and that we do have patients' best interests as our primary concern. Thus, the ethical defenses for whistle-blowing are many and the need is well established.

However, what about the applied part? How do you take this ethical obligation chairside? Is it not extraordinarily uncomfortable to point out a colleague's errors to her? Is it not even more uncomfortable for a dental hygienist to point out a dentist's errors to him or her? How does one handle such whistle-blowing situations without making enemies or risking one's job?



Let's explore the answers to all these questions by considering the following case.

Dr. J's Practice

Ms. B is a dental hygienist who has practised in the same office for the past five years. A colleague of Ms. B's who practises in another office (Dr. J's office) is going on a six month maternity leave and requests that Ms. B fill in for her two days per week during this time. Ms. B agrees to this.

During the first month that she is substituting for her colleague, Ms. B notices several adult patients who had been receiving regular (twice per year) hygiene treatment, who have 5 to 8 mm generalized probing depths and moderately heavy subgingival calculus. In Ms. B's experience, these are the type of advanced periodontal cases that she normally refers to the periodontist. These patients' records do not include any notations of pocket depths, periodontal treatment classifications, or referrals to a periodontist. In addition, some patient's radiographs are 8 or more years old. Most chart entries consist of "scale and polish" and "re-exam — no new problems." Ms. B is also concerned that many patients have medical histories that are over 5 to 10 years old and few have any record of blood pressures being taken.

Ms. B regularly calls Dr. J over to reexamine the patient when she completes treatment. She also calls his attention to pocket depths, areas of bleeding, furcation involvements, mobilities, and other indicators of significant periodontal disease. After his examination Dr. J invariably informs the patient that everything "looks okay," except for the occasional patient who needs limited restorative treatment which he does quite well.

This case contains elements related to both of these ethical dilemmas. What does the dental hygienist do when she encounters improper care provided by another dental hygienist, and what does she do when she encounters improper care provided by the dentist? We see several instances of substandard care by both the dentist and the former dental hygienist; uncharted periodontal pockets, subgingival deposits in patients who are receiving regular prophylaxes, old and incomplete medical histories, outdated radiographs. All of these items seem to implicate the dentist and dental hygienist as co-conspirators in supervised neglect of their patients.

Cases such as this call upon you to voice your values so that patients are protected, however, the former dental hygienist is a friend and the dentist is a nice enough guy, certainly not someone you would deliberately harm.

Think about your *personal* reaction to this practice. Would you send your spouse, child, parent, or other loved one to these providers? Think about your *professional* reaction to this practice. Do you wish for all of dentistry to be judged by *this* level of care? How do you, as an ethical provider, rectify this situation?

I would suggest that you begin by considering pertinent statements from Codes of Ethics from your profession and from related professions — Dentistry and Medicine. For example, the **CDHA Code of Ethics**



states “the **first** consideration of the dental hygienist who suspects incompetence or unethical conduct by members of the dental profession should be the welfare of present [patients] and/or potential harm to future [patients].” Similarly, the **ADHA Code** echoes this sentiment in its statements that providers must practice utilizing uncompromised professional judgment and that we must generate public confidence in the profession. The **CDA’s Code of Ethics** states that “a Dentist has an obligation to report to the appropriate review body, unprofessional conduct or failure to provide treatment in accordance with the currently acceptable professional standards”. **Medicine’s Code of Ethics** reiterates this perspective in its statement that “physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues...”

I would also encourage you to read further in these statements. Dentistry’s Code also states that “patients should be informed of their present oral health status without disparaging comment about prior services”. Medicine’s Code of Ethics expresses similar concerns regarding how patients are told of inadequate or harmful treatment.

Now, let’s put these statements from Codes of Ethics together with some moral values derived from our *personal* lives.

Most everyone learned at an early age to “do unto others as you would have them do unto you.” How would *you* want *your* colleague to inform you of an oversight or error on your part? What would *you* want them to say to the patient who was treated by you just one month ago but who demonstrates an overlooked or untreated area?

Most of us would prefer to be personally advised of what the colleague observed and be given the opportunity to rectify the situation. Most of us would want the patient advised of the problem, without disparaging comments, and further advised that, while the present condition does not represent an ideal outcome of treatment, it does occur from time to time and the important thing is that we recognize it in a timely fashion and rectify the situation. In such cases, where patients have received inadequate or even harmful treatment either at one’s own hands or at the hands of a colleague, beneficence requires that we be truthful with them so as to avoid further harms and benefit them in so far as possible.

How does one handle such whistle-blowing situations without making enemies or risking one’s job?

This revelation of truth must be done however, in a manner that addresses the concerns expressed in the Codes of Ethics. Making disparaging remarks about colleagues serves the interests of no one and casts the *profession* in a disadvantageous light. This may result in harms coming to others who hear unfortunate, derogatory remarks about the profession and who subsequently avoid dental treatment out of distrust for dental providers. All in the profession must realize that colleagues may make technical or judgment errors without being deficient in moral character or competence. Very few health care providers are ever intentionally negligent. Most patients can understand and accept that no human can perform 100% perfect work 100% of the time. Health care is both art and science and no treatment has a 100% success rate. There is no practitioner who is infallible. While providers may strive for perfection they must accept pragmatic guidelines in evaluating that treatment which is biologically compatible and func-

tionally acceptable. Certainly, anyone who performs direct patient care can recall instances in which the results of treatment were less than ideal. Such results may be due to practitioner misjudgment or to lack of patient cooperation or compliance.

“the first consideration of the dental hygienist who suspects incompetence or unethical conduct by members of the dental profession should be the welfare of present [patients] and/or potential harm to future [patients].”

However, the situation presented in this case is somewhat different than a bit of overlooked subgingival calculus. The hygienist is confronted with clear evidence of gross and continual faulty treatment in this practice. It is situations like this that self-policing is meant to address. If you allow such a malpracticing practice to continue unchallenged, you become part of the problem. You also become legally liable if patients in this practice are ultimately harmed. The patient’s attorney will make the point that, as a licensed dental hygienist, you either knew or should have known that these patients were being treated below acceptable standards.

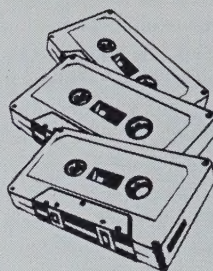
Fortunately, your approach to whistle-blowing need not place you in an impossible situation. As ethical health care providers, you are held to identifying gross and continual faulty treatment and then advising the appropriate review board. You are not expected to confront or otherwise educate, discipline, or punish the malpracticing providers. The appropriate review board, usually peer review, is prepared to further investigate the practice and providers, review charts, examine patients if necessary, interview employees past and present, and determine a course of action. Your report to peer review may be anonymous if you prefer, however, to be realistic, it is likely that those being reviewed will figure out the source of the report. Nonetheless, if your choice is doing nothing in the face of harm being done to patients versus becoming involved and looking out for the community of patients and the profession, the ethical choice seems clear.

Perhaps the most difficult moral transformation for caregivers who question their obligation to yield to a code of professional ethics, is recognizing that, while we all are entitled to certain rights as individuals, rights that arise from both our private lives and our professions, we are also held to corollary responsibilities. Every right carries with it a parallel responsibility. Thus, while the provider has a right to select patients in her practice, she has the responsibility not to base that selection process upon prejudice. While the provider has a **right** to practice without unreasonable interference, she has a **responsibility** to acquiesce to self-policing by the profession. While the provider has the **right** to hold a strong set of personal moral beliefs, she has the **responsibility** not to use those personal beliefs as a weapon to assault patients who do not hold the same beliefs. While the provider has a **right** to voice her values, she has the **responsibility** to recognize and accept her profession’s collective values in her practice.

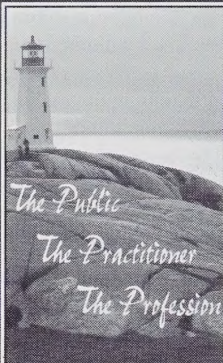
In short, health care providers occupy a unique position in society in that they are expected to develop morally as individuals and also to develop ethically as providers. In their practices, they are responsible for reaching some workable synthesis of these two moral spheres,

always remembering that the synthesis must be for the benefit of all who come to them as patients.

Editor's Note: *Dr. Chiodo's presentation also considered ethical dilemmas arising from the restriction in the ability of the dental hygienist to provide dental hygiene care because of the requirement to practice under the direct supervision of a dentist; the observed situations in which failure to refer a patient to a specialist resulted in an overall decline in patient dental health; the observed substandard infection control practices. In each situation the ethical dilemma was illustrated with an actual case and a practical ethical decision making process was discussed. This presentation, in its entirety, is available through CDHA's Audio Cassette Sales of Professional Conference presentations (Order Form can be found in Vol. 28 No 5 of Probe.) These audio cassettes are valuable resources to dental hygiene program curriculum, study groups, and/or continuing education workshops.*



An Audio-tape of the full presentation is available through CDHA's Central Office. See *Probe*, Vol. 28, No. 5 (p.174) for an order form or call Donna at 1-800-267-5235.



LAST CALL FOR ABSTRACTS Posters/Oral Papers/Table Clinics CANADIAN DENTAL HYGIENISTS ASSOCIATION

6th Annual Professional Conference

June 16-18, 1995 • The Sheraton Halifax • Halifax, Nova Scotia

Submissions of abstracts for free papers, posters, and table clinic presentations which are related to any aspect of dental hygiene practice are invited. Your intent to submit an abstract, including your name and title of the abstract, must be made known to the CDHA Conference Co-ordinator by December 15, 1994.

The deadline for submissions of abstracts for free papers, posters and table clinics is February 15, 1995. Selection will be on the basis of the quality of abstracts. Notification to authors of accepted or rejected abstracts will be made by March 15, 1995. All selected abstracts will be published in the Conference Program.

Completed papers must be submitted by April 10, 1995 for potential publication in *Probe*, CDHA's scientific journal.

For additional information contact: CDHA Central Office, Centrepointhe Chambers, 96 Centrepointhe Drive, Nepean (Ottawa), ON, K2G 6B1

Authors should submit one copy of Appendix A by February 15, 1995.

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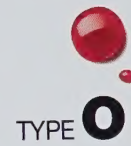
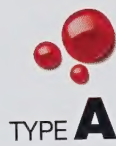
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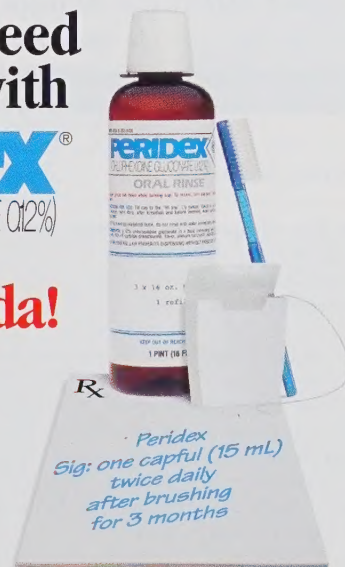
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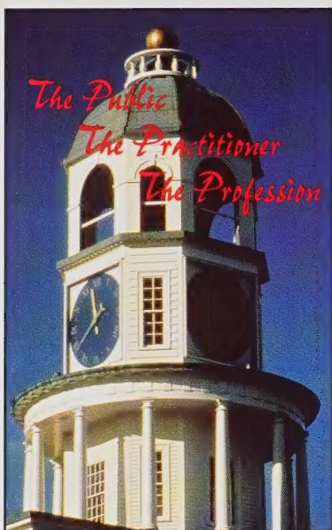
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CDHA 6th Annual Professional Conference

June 23-25, 1995

Halifax, N.S., Sheraton Halifax

**CHANGE OF DATES
DUE TO G-7 MEETINGS**

Plan to Discover Halifax on Foot while Attending CDHA's 6th Annual Professional Conference!

The 1995 Local Organizing Committee will be offering 'Walking Tours' of downtown Halifax to delegates attending CDHA's 6th Annual Professional Conference. Here are some of the highlights to be included on the tour:

- **Halifax Citadel** — This star-shaped fort affords one a spectacular view of the second largest harbour in the world — the Halifax Harbour!
- **Old Town Clock** — (*This is the monument that was selected by the Local Organizing Committee to represent Halifax on the 1995 CDHA Conference Logo you've seen appearing in newsletters and Probe!*) The Old Town Clock was a gift from Queen Victoria's father, the individual who commanded the British Army in Halifax more than 200 years ago! You will also have a chance to view Canada's first Art College, founded by Anna Leonowens (the famous subject of "The King and I" story). This site is now home to the Five Fishermen Restaurant.
- **St Paul's Anglican Church** — First opened in 1750, this building has withstood all of the changes in Halifax's fortune. It bears witness to many famous battles, including both world wars, and has its own reminders of the Halifax explosion of 1917. Site of the Remembrance Day Ceremonies held annually in Halifax.
- **Fine examples of Victorian and Georgian Architecture** — Halifax is replete with fine historical replicas of the Victorian and Georgian era amidst its modern city landscape. Province House, recently designated of national historical significance by Her Majesty Queen Elizabeth, boasts the precedents of both freedom of the press and representative government.
- **Privateers Wharf** — This is a monument to Halifax's seafaring history. The old warehouses remind one of pirates and privateers. Today, it is home to a multitude of stores, boutiques, restaurants and pubs and is located across the compound from the Sheraton Halifax (site of CDHA's 6th Annual Professional Conference).
- **HMCS Sackville** — The last Covette, representing Nova Scotia's proud naval tradition.
- **Maritime Museum of the Atlantic** — Located on the waterfront, this museum contains artifacts from the Titanic sinking (1912) as well as fine exhibits of a famous sailing heritage.

After the Walking Tour you may choose to visit Province House, the Museum, HMCS Sackville, take a short ride on the oldest saltwater ferry in North America or settle down for a snack at one of the many pubs and restaurants in downtown Halifax.

Or, take a walk along the waterfront and follow in the footsteps of Leon Trotsky, Charles Dickens, Adele Hugo and Captain Kidd!

Need Continuing Education Credits?

Attend CDHA's 6th Annual Professional Conference — A Prime Opportunity to Earn CE Units and Meet With Your Colleagues From Across the Country

Here's a glimpse of some of the Educational Opportunities awaiting you next June in Halifax — read *Probe* regularly for more details.

Friday, June 23

3:30 - 5:00 PM

The Use of Lasers in Dentistry and Dental Hygiene

JoAnn Gurenlian, RDH, PhD
Haddonfield, New Jersey

This course is designed to familiarize the dental hygienist with the use of LASERS in dentistry and dental hygiene. Principles of lasers, types of laser equipment, effects of lasers on dental tissues and advantages and disadvantages of lasers will be addressed. Participants will have an opportunity to explore the current and future applications of lasers to dental hygiene education, research and practice.



Saturday, June 24

8:30 - 10:00 AM

Diagnostic Decision Making: Formulating the Dental Hygiene Diagnosis

JoAnn Gurenlian, RDH, PhD
Haddonfield, New Jersey

Following assessment procedures, the next phase of the dental hygiene process of care is determining the dental hygiene diagnosis. The diagnosis serves as the basis for treatment planning, providing preventive and therapeutic services, and evaluating the achievement of goals to obtain client health. In this course, the diagnostic decision making process will be described and periodontal and pathology case study reviews will be conducted.

Saturday, June 24**2:00 - 3:45 PM****Stress Management: Strategies for Treating Our Patients and Ourselves**

T. Michael Vallis, BSc, MA, PhD
Halifax, Nova Scotia

This presentation will deal with stress as it is manifested in the dental situation; both in the dental patient and the dental staff. Strategies for assessment and treatment will be presented, geared for the practising hygienist. A broad range of topics will be covered, including: how to identify signs of stress, both in patients and in oneself; the principles of stress management (including relaxation, distraction, assertiveness, cognitive restructuring, and self-efficacy training); and strategies for adapting the principles of stress management for the office practice. The course will involve a blending of lecture, case presentation, and experiential learning of management techniques.

The goals of this presentation are to increase the participant's ability to identify stress in dental patients as well as in themselves; to enable the participant to assess the seriousness of the problem and plan intervention; to train the participant in stress-reduction techniques, and to facilitate the implementation of stress-reduction techniques in the office setting.

Saturday, June 24**4:00 - 5:00 PM****The Role of Local Drug Delivery and the Changing Role of Ultrasonics**

Kimberly Krust-Bray, BSc(DH), MSc
Pleasant Valley, Missouri

Sponsored by: **DENTSPLY**
CANADA

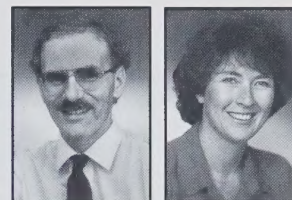
This session is designed to provide participants with a summary of Fiber Research including an examination of the synergistic relationship between tetracycline fiber therapy and scaling and root planing. In addition it will comment on the significance of healing following fiber placement alone in the absence of scaling entirely. In addition, participants will be provided with an historical view of ultrasonic use and research results. Topics to be addressed will include: a discussion of the advantages of ultrasonics, an introduction to the Slimline design, comparison of the performance of modified and standard ultrasonic tips and hand scaling curettes.

June/95									
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**CIRCLE
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JUNE 23-25,
1995**

Sunday, June 25**8:30 - 10:00 AM****Work Smart! Preventing and Managing Injuries in the Work Place**

Dan Boland, MScPT, MCPA
Shirley McCarthy, BSc(OT), RegNS
Halifax, Nova Scotia



Dental Hygienists spend extended periods of time in stressful postures while at work. It is realized that some of these awkward, sustained positions are unavoidable. However, through appropriate education, many potential injuries can be avoided.

This presentation will cover various aspects of injuries which are incurred by Dental Hygienists while performing job tasks. Major focuses will include: pathology of overuse injuries and cumulative trauma disorders, early intervention strategies, ergonomics in the workplace, self-management and prevention.

Sunday, June 25**8:30 - 11:00 AM****Periodontal Debridement**

Kimberly Krust-Bray, BSc(DH), MSc
Pleasant Valley, Missouri

Sponsored by: **DENTSPLY**
CANADA

This presentation will focus on periodontal debridement vs. scaling and root planing. It will include a historical review of periodontal philosophies, a discussion of the residual calculus paradox, methodologies used to assess residual calculus, cementum removal and the role of endotoxin.

Sunday, June 25**10:00 - 11:30 AM****Discrimination and the Socially Unacceptable Patient**

Chris Robb, Dip DH, BA
Halifax, Nova Scotia

This workshop is designed to explore the ethical and psycho social gap which exists between our intellectual acceptance of the universal precautions of infection control, as recommended by the Center for Disease Control, and the personal anxieties and fears we inadvertently exhibit when treating the socially undesirable patient. This will be accomplished through an examination of scientific, clinical and historical perspectives of HIV/AIDS. Increased knowledge and awareness will help ensure that all patients are treated with mutual trust, confidence and respect.

**Next issue we will feature:****Title TBA**

Jane Fulton, PhD, Ottawa, ON

Medical Histories and Pharmacology

Choong Foong, BSc(Hon), PhD, Halifax, NS

Dental Hygiene Dermatology Issues

Chris Gallant, MSc, MD, FRCP(C), Halifax, NS

Oral Pathology*

Barbara Harsanyi, BA, DDS, MS, FRCD(C), Halifax, NS

*denotes session to be simultaneously translated

Legalities of Recordkeeping*

Burghind Gregg, Dip DH, BA, LLB, Halifax, NS

Panel Discussion on Self Regulation*

with Brenda Walker, Dip DH of Edmonton, AB
Pat Grant, Dip DH, BA of Halifax, NS
Bob Konopasky, PhD, C.Psych of Halifax, NS
Marilyn MacKay-Lyons, MSc(PT), BSc(PT), Dip PT of Halifax, NS
moderated by Lynda McKeown Mickelson, RDH, HBA of
Thunder Bay, ON

The Dilemma

A dental hygienist is employed by a dentist who is concerned about mercury poisoning and mercury vapors produced by amalgam restorations. He has even published an article on the subject. The dentist has a mercury testing device which the hygienist is required to use on patients during examinations. The dentist recommends, to all of the patients, that they replace their amalgams with composite resins, regardless of whether the restorations were bulky, involved interproximal contact, were intact, or even if the patient was not a good candidate for resins (e.g. bruxism).

The dental hygienist notices on subsequent recall that many of these replaced restorations have defects in the margins and/or have severe wear patterns due to bruxing problems. Often the patients would ask the hygienist's professional opinion about either the replacement of amalgams or the quality of the work.

The hygienist feels uncomfortable about using the "mercury tester" and about promoting the dentist's practices. She also feels torn between loyalty to her employer and her ethical obligations to her patients. In addition, she doubts the quality of the work done.

Not wanting a confrontation, she leaves the practice within several months without voicing her opinion or reasons for leaving.

Gather Facts:

- The dentist is concerned about mercury vapors and amalgam restorations.
- The hygienist is required to use a "mercury tester".
- The dentist recommends that all the patients replace their amalgam restorations with composite resins.
- Information given to the patients is not generally recognized or accepted by the dental profession.
- Noticeable defects are found in the new composite restorations.
- Patients ask the hygienist her advice and opinion, placing the hygienist in an awkward position.
- The hygienist is not in agreement with the dentist's practices.
- The hygienist leaves her job without disclosing her reasons to the dentist.

Identify Relevant Values

Principle 3: Veracity and Informed Consent

One critical element of this principle is the disclosure of pertinent information. Information given to the patient in this case is one-sided and neither scientifically supported nor endorsed by the dental profession. Use of the mercury tester could be considered a manipulative tactic used to obtain consent. The dental hygienist should be able to respond freely to the clients' requests for information and provide explanations when possessing the knowledge to respond accurately. The hygienist in this case evades such questions because she feels awkward about voicing an opposing opinion.

Principle 4: Beneficence and Quality Assurance

The hygienist accepted employment in an office where the provision of care did not seem to be consistent with the Code of Ethics. Ethical expectations were not established at the beginning of the employer/employee relationship.

Principle 5: Justice

As a member of the dental profession, the dental hygienist is obligated to ensure the client receives competent, ethical care. In a case of suspected incompetency or unethical conduct such as this, the primary consideration should be the welfare of the present clients. Since the hygienist did not approach the dentist, and no steps were taken to inform the licensing body, the dentist's current questionable practices were allowed to continue.

Options:

1. Stay with the practice and not approach the dentist.
(This option does not address any of the ethical principles and could lead to feelings of guilt on the part of the hygienist.)
2. Stay with the practice and approach the dentist.
(If the hygienist chose this option she would be fulfilling her obligation to take steps to ensure that the clients received ethical, competent care (Justice) and also her obligation to invoke changes to improve the quality of care (Beneficence and Quality Assurance) if the dentist agrees to practice in accordance within the accepted standards of the dental profession.)
3. Approach the dentist and leave the practice.

(This solution would address the same ethical principles as #2 but the hygienist would not know if any changes for the better regarding this issue took place. Feelings of hurt and resentment may make it difficult for the hygienist to stay with the practice.)

4. Do not approach the dentist and leave the practice.
(Like option 1, this solution does not address any of the ethical principles involved, and there is no benefit to the patients.)

Choose:

In this case Option 2 is probably the one that is the most beneficial for all involved. However, if the dentist does not change his practice to be in accordance with standards established by the dental profession, then the hygienist may feel obligated to report him to the licensing authority. If this is the case than Option 3 is the more likely choice.

Act:

We would act according to option 2, but if the dentist continued to practice as usual I would feel an obligation to report it to the licensing authority and to leave the practice.

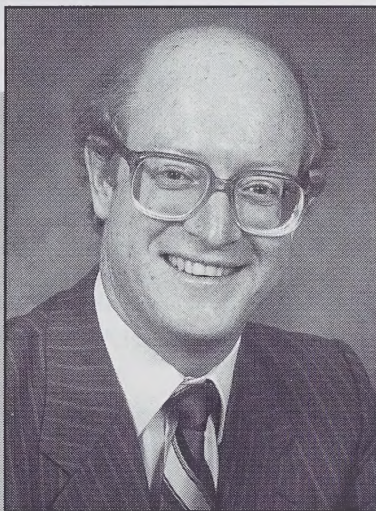
By:
Nancy (Prowse) Neish, BA, Dip DH, MEd
Brenda Fortune, Dip DH



The Role of Dental Hygienists in the Challenges of Health Care Reform

*based on a presentation delivered by Dr. Michael Rachlis
prepared by: Susanne Sunell, Dip DH, BA*

Prior to the official opening of CDHA's 5th Annual Professional Conference (held in Saskatoon, SK, June 17-19, 1994), Dr. Michael Rachlis challenged the CDHA Board Members to be innovative and creative in the development of new health care delivery models. He said most health care providers have come to realize that treating illness will not make a population healthy. And furthermore, that stagnating government revenues and escalating costs have accentuated the structural deficiencies in the Canadian fee for service health care system. During the morning session Dr. Rachlis addressed the limitations of our current system, the barriers to change and visions for the future. The discussions included strategies for promoting change, and positioning the Dental Hygiene profession to meet the challenges of new directions in health care. This report highlights elements of the discussions with Dr. Rachlis.



DR. MICHAEL RACHLIS

Political Frame

Politics is not a "dirty word", rather a decision making process which allows for the positioning of various interest groups. Interest groups can be analyzed from the perspective of dominant groups and suppressed groups. Dominant groups are given power by the structure of the system which provides opportunities for meetings and decision-making authority. Suppressed groups are often difficult to mobilize, as they have less opportunities to meet and organize with the support of the system. These characteristics are significant in understanding changes in the political equation as new institutional arrangements create new dominant interest groups.

Impetus for Change

The main impetus for health care reform involves the structural inefficiencies of our current system. These are not related to the practitioner, but rather to the entire system. A study with chronically ill male veterans attending a Vermont out-patient clinic suggested that telephone care/contact was an effective substitute for routine clinical follow-up visits. The results indicated that the study group had significantly fewer medications, clinical visits, general bed days, hospital bed days and overall lower health care costs, than the control group

members who continued with their regular schedule of visits. This study suggests a valuable intervention strategy, but one which can not be integrated into our current structure which supports fees for specific services. The rigidity of the current system, its focus on the treatment of illness rather than the promotion of health, and its cost, have resulted in demands for change.

Barriers to Change

The proponents of change are faced with a number of barriers including the public's belief system, the institutional benefits bestowed by the current system, and the absence of a coalition for change. Realizing the limitations of treating disease, health care providers have shifted their attention to prevention and health promotion. The public, however, has not integrated this new paradigm. The commonly held belief suggests that if we live long enough, health care will cure all illness. Treating disease is currently the most valued aspect of health care. Influencing the current public

beliefs and values, or waiting for a new generation to adopt the values of the new paradigm may take another ten to fifteen years. The incumbents, the dominant interest groups, possess power and benefits from the current system which are difficult to abdicate. The negotiations between governments and medical associations, do not allow for significant movement of dollars within the system, thus providing an effective vehicle for maintaining the status quo. It is also unrealistic to expect institutions to plan their own demise. The recent shift to regionalization of hospitals and regional boards has decreased the autonomy and power of individual institutions to some degree. However, there is no real coalition for change, no organized movement and no organizational structures to support reform of the health care system. These combined factors present some real challenges to the impetus for change.

New Directions:

The major focus in health reform is directed at innovations in the delivery of care. The first step is the definition of comprehensive health care goals and standards that can be measured in health outcomes. Currently most goals relate to structure, the number of beds per 1,000 population for example, as opposed to health outcomes such as mortality

ty rates, functional status of the elderly, and low birth weight rate. Dr. Rachlis views the role of government as "steering" the direction of services by defining outcome indicators to guide funding and operational decisions, and promoting primary care centres to develop innovative and entrepreneurial strategies. A funding formula based on capitation principles could provide different incentives for the delivery of care, expropriate the right to primary care from doctors, and permit other professionals to apply for community health care licenses. Such a system would also allow individuals to select the style of practice which would best meet their needs. By breaking down the structural barriers of our current system, new modes of delivery may be created.

The model proposed by Dr. Rachlis involves the creation of community health care centres which would integrate with regional health care facilities. These centres would provide the following types of services.

Primary Care including:

- medical
- nursing
- rehabilitation
- social services
- dental (dental hygiene, dental therapy, dental assisting, dentist, dental, etc.)
- long term care
- mental health
- most secondary medical care

Most community hospital care

Laboratory and diagnostic services

Pharmaceutical services

In addition, community health centres could provide:

Health Promotion Services

School Health

Occupational Health Services

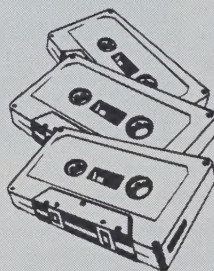
This approach could lead to the development of innovative delivery systems allowing for the balance of quality care with increased access and cost effectiveness. Accountability could be measured through health care outcomes based on the characteristics of the population serviced by the community centres.

Role of Dental Hygienists as Agents for Change

Since the current system supports the dominant interest groups, it is the mandate of the suppressed interest groups to develop an organized movement for change. This can be accomplished by developing coalitions both provincially and nationally with other health care profes-

sionals and the public. Debate the issues in a public forum to encourage government focus and accountability. The rhetoric of health care reform has been used to implement budget cuts across the board, without subsequent reallocation of the dollars. If the responsibility for patients is shifted, the dollars also need to be moved. Health boards need to have clearly defined goals and outcomes to guide them in the decision making process. Develop support for broadening the care providers involved in primary care, for implementing collaborative health care models directed at community health, and for health promotion strategies. Supporting health care centres which focus on cost effective quality care in association with appropriate professionals, would encourage the integration of dental hygienists into the health care system. This collaborative model also needs to be integrated into the educational setting. The common core elements of health care curriculum, need to be implemented in an integrated environment to allow for the development of team work strategies among all care providers. Historically dentistry and medicine shared a common educational base. This must be reestablished with a broader scope to include all health care providers, both in the educational and the practice environment.

CONCLUSION: Dental hygienists' role as agents for change have been described in many professional articles. The workshop with Dr. Rachlis provided insights into the implications of this role in the sphere of health care reform. Develop coalitions with other care providers, articulate values and options in discussions with your patients and clients, contact political constituency representatives, and debate the issue in public forums. According to Dr. Rachlis, stagnating government revenues may have produced a window of opportunity for Dental Hygienists to assume greater responsibilities in general health and oral health care delivery systems.



An Audio-tape of the full presentation is available through CDHA's Central Office. See *Probe*, Vol. 28, No. 5 (p.174) for an order form or call Donna at 1-800-267-5235.



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Calendar

		<i>SPONSOR</i>	<i>LOCATION</i>	<i>FOR INFO CALL</i>
November 1994				
19	X-Ray X-Cellence — Part I — Barry Pass, DDS, MSc, PhD & Tom Blackmore, B.Eng., DDS	Dalhousie University, Faculty of Dentistry	Dalhousie University, (902) 494-1674 Halifax, NS	
19	Practical Periodontics — Dr. James Simonds	University of Manitoba	Winnipeg, MB	(204) 789-3331
23	CPR Recertification — Dr. Ron Boyar, Mrs. Janice Wood	University of Manitoba	Winnipeg, MB	(204) 789-3331
26	Update and Review of Common Oral Pathologic Conditions — Drs. Raborn, Petrikowski, Peters, McGaw	University of Alberta, Faculty of Dentistry	Edmonton, AB	(403) 492-5023
December 1994				
3	Incorporating Periodontics into General Practice — William J. Killoy, DDS, MS, FACD	Dalhousie University, Faculty of Dentistry	Dalhousie University, (902) 494-1674 Halifax, NS	
3-6	VI General Dental Hygiene Congress	Spanish Dental Hygienists Federation	Valencia, Spain	(96) 342 04 22
January 1995				
7	Pharmacology Update — Fred Wowan, John Smith	University of Oregon, Continuing Dental Education	Portland, OR	(503) 494-8857
9-13	Dental Education in Care of the Disabled	University of Washington	Seattle, WA	(206) 543-5448
21	CPR for the Dental Team — Dr. Ron Boyar, Mrs. Janice Woods	University of Manitoba	Winnipeg, MB	(204) 789-3331
February 1995				
1	Professional & Ethical Liability — Brian Curial	Southern Alberta Dental Hygienists Society	Foothills Hospital, Calgary, AB	Barbara at (403) 284-0060
7	Investments — Don White, Royal Bank	Northern Alberta Dental Hygienists Society	Westin Hotel, Edmonton, AB	(403) 481-7975
25-March 4	Eastern Caribbean Cruise and Course at Sea — Kenneth Zakariasen, BA, DDS, MS, PhD — Keith Compton BSc, DDS, MS — Dwight Castleberry, DMD, MS — Sharon Compton, RDH, BSc, MA(Ed)	University of Alberta/ University of Alabama/ Marquette University		(800) 661-6597
25	Medical History: Assessing the Risk in Treatment — Ms. Eunice Edgington	Manitoba Dental Hygienists Association	Winnipeg, MB	(204) 789-3331
25	Dentistry in the Age of AIDS — Dr. L.G. Horowitz	College of Dental Surgeons of Saskatchewan	Regina, SK	(306) 244-5072
November 1995				
23-25	13th International Symposium on Dental Hygiene <i>If you want to be on the mailing list for announcements and program information write to:</i> The Japanese Dental Hygienists' Association c/o Shikaishi Kaikan, 4-1-20 Kundankita, Chiyodaku, Tokyo 102 - Japan	Intl. Fed. of Dental Hygienists	Tokyo, Japan	

CDHA's Book of the Month Suggestions

November:
Kids Are Worth It
*Give Your Child the
Gift of Inner Discipline*

Barbara Coloroso
ISBN 0-921051-74-3 HC
Somerville House Publishing
Toronto 1994

Continuing
Education
At Home

December:
Free to Feel Great
*Teaching Children to
Excel at Living*

Terry Orlick, PhD
ISBN 0-921165-26-9
Creative Bound Inc.
Carp, ON 1993

PerioREPORTS

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Journal of Clinical Periodontology
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Journal of Dental Research
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J of Periodontics and Restorative Dent
JADA, JADHA
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ACTIONS, CLINICAL PHARMACOLOGY: Peridex Oral Rinse (0.12% Chlorhexidine Gluconate) or Peridex provides antimicrobial activity during oral rinsing which is maintained between rinsings. Microbiologic sampling of plaque has shown a general reduction of both aerobic and anaerobic bacterial counts ranging from 54-97% through six months' clinical use. Rinsing with Peridex inhibits the buildup and maturation of plaque by reducing certain microbes regarded as gingival pathogens, thereby reducing gingivitis. Peridex provides antimicrobial activity during rinsing and for several hours thereafter.

No significant changes in bacterial sensitivity, overgrowth of potentially opportunistic organisms or other adverse changes in the oral microbial flora were observed following the use of Peridex for six months. Three months after Peridex use was discontinued, the number of bacteria in plaque had returned to pre treatment levels and sensitivity of plaque bacteria to chlorhexidine gluconate remained unchanged.

Studies conducted with human subjects and animals demonstrate that any ingested chlorhexidine gluconate is poorly absorbed from the gastrointestinal tract. Excretion of chlorhexidine gluconate occurred primarily through the feces (approximately 90%). Less than 1% of the chlorhexidine gluconate ingested by these subjects was excreted in the urine.

INDICATIONS AND CLINICAL USE: Peridex is indicated for use as part of a professional program for the treatment of moderate to severe gingivitis, and for management of associated gingival bleeding and inflammation between dental visits. For patients having coexisting gingivitis and periodontitis, see PRECAUTIONS.

CONTRAINDICATIONS: Peridex should not be used by persons who are known to be hypersensitive to chlorhexidine gluconate or other formula ingredients.

WARNINGS:

USE IN PREGNANCY: Reproduction and fertility studies with chlorhexidine gluconate have been conducted. No evidence of impaired fertility was observed in male and female rats at doses up to 100 mg/kg/day, and no evidence of harm to the fetus was observed in rats and rabbits at doses up to 300 mg/kg/day and 40 mg/kg/day, respectively. These doses are approximately 100, 300, and 40 times that which would result from a person ingesting 30 ml (2 capfuls) of Peridex (0.12% chlorhexidine gluconate) per day. Since controlled studies in pregnant women have not been conducted, the benefits of use of the drug in pregnant women should be weighed against possible risk to the fetus.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. In parturition and lactation studies with rats, no evidence of impaired parturition or of toxic effects to suckling pups was observed when chlorhexidine gluconate was administered to dams at doses that were over 100 times greater than the dose which would result if a person ingested the entire recommended dose of Peridex (0.12% chlorhexidine gluconate) on a daily basis.

USE IN CHILDREN: Since the safety and efficacy of Peridex in children has not yet been fully established, the benefits of its use should be weighed against the possible risks.

PRECAUTIONS:

1. For patients having coexisting gingivitis and periodontitis, the absence of gingival inflammation following treatment with Peridex may not be indicative of the absence of underlying periodontitis. Appropriate treatment of periodontitis is therefore indicated.

2. Peridex may cause staining of oral surfaces such as the film on tooth surfaces, restorations, and the dorsum of the tongue. Stain will be more pronounced in patients who have heavier accumulations of unremoved plaque.

Stain resulting from use of Peridex does not adversely affect the health of gingivae or other oral tissue. Stain can be removed from most tooth surfaces by conventional professional prophylactic techniques. Additional time may be required to complete the prophylaxis.

Discretion should be used when treating patients with exposed root surfaces or anterior facial restorations with rough surfaces or margins. If natural stains cannot be removed from these surfaces by a dental prophylaxis, patients should be excluded from Peridex treatment if the risk of permanent discoloration is unacceptable. Stains in these areas may be difficult to remove by dental prophylaxis and on rare occasions may necessitate replacement of these restorations.

3. A few patients may experience a slight and temporary alteration in taste perception while undergoing treatment with Peridex. Most of these patients accommodate to this effect with continued use of Peridex.

4. For maximum effectiveness the patient should avoid rinsing their mouth, eating or drinking for about 30 minutes after using Peridex.

ADVERSE REACTIONS: No serious systemic reactions associated with use of Peridex were observed in clinical testing. However, some adverse reactions have been reported in studies with Peridex or other chlorhexidine-containing mouth rinses. The most common side effects associated with chlorhexidine gluconate oral rinses are (1) an increase in staining of oral surfaces, (2) an increase in supra gingival calculus and (3) a slight and temporary alteration in taste perception. (see PRECAUTIONS). Epithelial irritation and superficial desquamation of the oral mucosa have been noted in studies of children using 0.12% chlorhexidine gluconate which were reversible upon discontinuation.

There have been rare cases of parotid gland swelling and inflammation of the salivary glands, in patients using Peridex.

SYMPTOMS AND TREATMENT OF OVERDOSAGE: Ingestion of 30 or 60 ml of Peridex (0.12% chlorhexidine gluconate) by a small child (10 kg or less body weight) might result in gastric distress, including nausea, or signs of alcohol intoxication. Medical attention should be sought if more than 120 ml of Peridex is ingested by a small child or if signs of alcohol intoxication develop.

DOSAGE AND ADMINISTRATION: Peridex therapy should be initiated directly following a dental prophylaxis. Patients using Peridex should be reevaluated and given a thorough prophylaxis at intervals no longer than six months; they should be referred for periodontal consultation as necessary.

Recommended use is twice daily oral rinsing for 30 seconds, morning and evening after tooth brushing. Usual dosage is 15 mL (marked in cap) of undiluted Peridex. Peridex is not intended for ingestion and should be expected after rinsing. Rinsing the mouth, eating or drinking should be avoided for about 30 minutes after using Peridex.

The suggested initial course of therapy is 3 months, at which time patients should be recalled for evaluation. At the time of the recall visit, the dental professional should:

- Evaluate progress, remove any stain, and reinforce proper home care techniques.
- If gingival inflammation and bleeding is controlled, discontinue Peridex therapy and recall the patient in three months to assess gingival health.
- If gingival inflammation and bleeding persists, continue Peridex therapy for an additional 3 months and schedule a three-month recall for evaluation.
- Evaluate for evidence of epithelial irritation, desquamation and parotitis.

The following generally accepted grading scheme may be of use in evaluating the severity of gingivitis.

Loe and Silness
GINGIVAL INDEX (GI)

Grade	Description
1	Normal gingiva, no inflammation, no discoloration, no bleeding.
2	Mild inflammation, slight color change, mild alteration of gingival surface. No bleeding.
3	Moderate inflammation, erythema, swelling, bleeding on probing or when pressure applied.
4	Severe inflammation, severe erythema and swelling, tendency toward spontaneous hemorrhage, some ulceration.

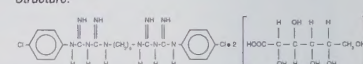
An occasional missed dose can be ignored if the patient is generally compliant with the prescribed regimen.

PHARMACEUTICAL INFORMATION DRUG SUBSTANCE

Proper Name: Chlorhexidine gluconate (U.S.A.N.)

Chemical Name: 1,1'-hexamethylene bis [5- (p-chlorophenyl) biguanide] di-D-gluconate

Structure:



Molecular Weight: 897.8

Description:

Chlorhexidine has basic character and exists in the di-cationic form at physiologic pH. The two protonic positive charges become somewhat localized on the bi-guanide portion of the molecule. Both pKa's are reported as 10.78 ± 0.06. The gluconate salt is soluble in excess of 70% (w/v) in water at 20°C.

At 19-21% w/v chlorhexidine gluconate solution is colourless to pale straw-coloured and is odourless to almost odourless (British Pharmacopoeia).

COMPOSITION: Peridex contains 0.12% chlorhexidine gluconate in a base containing water, alcohol, glycerin, PEG-40 sorbitan di-isostearate, flavour, saccharin sodium and FD&C Blue #1 Dye.

STABILITY AND STORAGE: Store above freezing (0°C).

INCOMPATIBILITIES: None known.

SPECIAL INSTRUCTIONS: None.

AVAILABILITY OF DOSAGE FORM: Peridex oral rinse (0.12% chlorhexidine gluconate) is supplied as a blue liquid in 475 mL amber plastic bottles with child-resistant dispensing closures.

Store above freezing (0°C).

REFERENCE

1. Grossman E., Reiter G., Sturzenberger OP, et al. Six-month study of the effects of a chlorhexidine mouthrinse on gingivitis in adults. *Journal of Periodontal Research*. 1986;21(suppl 16):33-43.

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Reviewed by:
Carol Barr Overholt, Dip DH

The Rise in Latex Allergy: Implications for the Dentist

By: **Hugh Ann Snyder, DDS**
Susan Settle, DDS
JADA, Vol 125, August 1994

Although recorded cases of latex allergy date as early as 1933, an unanticipated rise in anaphylaxis related to latex protein precipitated the U.S. Food and Drug Administration (FDA) to address this concern. This agency solicited physicians to identify any clients exhibiting this phenomenon. The Academy of Allergy and Immunology then reviewed the guidelines developed by the FDA.

When compared to the general population, dental personnel demonstrate an increased latex allergy incidence. The FDA estimate that 6-7% of surgical personnel may also be allergic. Additionally, those considered at risk for allergic reaction to latex include, atopic individuals (those with existing allergies i.e. hay fever, asthma, eczema), and individuals with spina bifida or other spinal cord deformities; some estimate that 18-40% of these clients will be allergic to latex. One health care group recommends that all spina bifida clients be considered allergic.

The number and duration of exposures to latex protein increases sensitivity. Health care personnel wearing gloves for long periods of time on a regular basis are therefore at increased risk. Similarly, clients exposed to numerous surgical procedures face this hazard.

As allergens are water-soluble, skin moisture exacerbates the problem, escalating the severity of some reactions. Cornstarch powder, lining the gloves, displays the ability to attach to the protein allergen allowing the protein to become airborne through aerosol production. In this case, no direct contact with the latex protein would be required to initiate an adverse reaction. While some of these allergens may be removed from the gloves with intensive washing, microholes may result, making the gloves ineffectual.

There is no standard latex protein allergy test currently available. The lack of a simple test is perhaps due to the difficulty in isolating the responsible protein from those precipitated in rubber processing. Some research indicates that additives involved in the processing induce Type IV allergies, manifested

as a clinical reaction seen 12-48 hours post-exposure. The irritation is localized to the exposed area. As dermatological testing is inconclusive, researchers hope for imminent serum analysis as a diagnostic tool.

Symptoms of a latex allergy in health care persons include erythema, pruritis, or rash, on the surfaces of the hands. The responses will vary with the individual. Reactions may be delayed or immediate. Some reactions proceed to a Type I immunologic response known as anaphylaxis. Symptoms of anaphylaxis include constriction of smooth muscles leading to an asthmatic response, diarrhea, edema, vomiting or incontinence. Subsequent dilation of the smooth muscles leads to a drop in blood pressure and shock. Six to twelve hours post-exposure, the slow phase begins. Symptoms include "painful erythematous induration of the skin and prolonged broncho-constriction, as well as increased gastric, respiratory, and lacrimal secretions." The range and extent of the reaction appears to depend upon the portal of entry, or route of transmission, of the allergen. Introduction of the latex protein directly into the bloodstream produces a more acute anaphylaxis than a procedure where contact, but no break in the integrity of the skin, occurs. The FDA indicates that mucous membranes (oral, vaginal, rectal) may be hypersensitive in a client with a latex allergy. Dental personnel should therefore be mindful of this.

Prevention of severe client allergic reactions, includes a thorough medical history including questions related to a sensitivity to balloons, rubber work gloves, athletic shoes etc. A common thread in several recorded cases was that the clients washed all rubber products prior to wearing them. Persons who have routine exposure to latex, or are involved in the production of rubber products, should be screened carefully.

The authors recommend that health care personnel have an office anaphylaxis treatment protocol available. Rapid triage and familiarity with basic medical emergency procedures is imperative. The differential diagnoses will encompass bronchial, vasovagal, cardiac reactions, and administration of sedation medications or local anesthesia. For example, fear, anxiety or epinephrine may produce symptoms of syncope, pallor, sweating, tachycardia, bradycardia or tremor.

ABSTRACT

These may be confused with a true anaphylactic reaction and must be ruled out.

Medications effective in the treatment of severe allergic reactions include, epinephrine, anti-histamines and CPR. Immediate transportation to a hospital for anaphylactic shock is recommended. Pharmaceutical companies have produced various products for intra-muscular injection of epinephrine including, Epi-Pen® and Ana-Kit®. The deltoid muscle is suggested as the safest injection site.

Manufacturers are not currently required to label products containing latex rubber. The authors, therefore, strongly suggest that dental office personnel develop a latex allergy identification and intervention policy.

The Most Needed Application for Dental Implants

By: **Gordon J. Christensen, DDS,
MSD, PhD**
JADA Vol 125, June 1994

The first decade of the use of dental implants is nearly complete and confusion still exists surrounding the most appropriate clinical indications for implants. Jaws that require distal extension, or are edentulous, trauma cases, or cleft palate clients may benefit from the procedure. The author maintains that "the severely resorbed edentulous mandible demands dental implants more than any other clinical situation." He argues that complete lower dentures provide little satisfaction for dental clients. Dr. Christensen goes on to discuss that the cost of placing 5-6 implants is prohibitive for the average-income population. He contends that two implants placed in the mandibular canine region, and supported by two "O" rings, offers a suitable, less expensive therapy option.

The technique for the procedure follows. Discussion includes diagnosis and treatment planning, implant and abutment placement, healing, and denture construction. Recall and repair appointments are also considered.

The author concludes that for clients with edentulous mandibles, the option of two implants followed by simple denture construction should be "considered standard care."



Periodontics

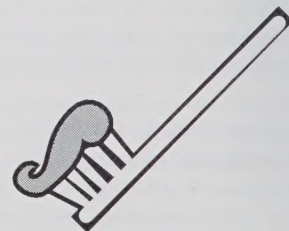


1. Tooth #14 has an angular bony defect near its mesial surface where there is an overhanging amalgam restoration, subgingival calculus, and only fair oral hygiene. The primary cause of the periodontal attachment loss is:
 - a) the overhanging restoration
 - b) the presence of calculus
 - c) plaque
 - d) the root morphology of this tooth
2. Success in oral hygiene instruction depends on one factor more than any other. Without this component of OHI, all other efforts will be rendered virtually redundant. This factor is:
 - a) demonstration by the clinician
 - b) demonstration by the patient under supervision
 - c) verbal explanation of techniques
 - d) a warm, caring attitude
3. The most effective instrument for root planing in the area of root furcations is:
 - a) the Columbia 4R/4L
 - b) a sonic instrument or ultrasonic scaler
 - c) a high speed round diamond bur
 - d) the Gracey 13/14
4. Aggressive root planing should be avoided:
 - a) anywhere calculus cannot be detected
 - b) at the very bottom 2 mm of a periodontal pocket
 - c) on root surfaces that are, or are likely to become, supragingival
 - d) in areas of hypercementosis
5. The location of the distal furcation on a maxillary molar is:
 - a) approximately halfway, in a buccolingual dimension
 - b) towards the buccal, in a buccolingual dimension
 - c) towards the palatal, in a buccolingual dimension
 - d) not important, since involvement of this furcation justifies extraction of the tooth
6. The location of the mesial furcation on a maxillary molar is:
 - a) approximately halfway, in a buccolingual dimension
 - b) towards the buccal, in a buccolingual dimension
 - c) towards the palatal, in a buccolingual dimension
 - d) not important, since involvement of this furcation justifies extraction of the tooth
7. By definition, "root planing" differs from "scaling" in that:
 - a) root planing is aimed at removing contaminated cementum and dentin
 - b) scaling is aimed at removing supragingival plaque, calculus and stain
 - c) root planing is aimed at removing plaque, calculus and stain
 - d) scaling is aimed at removing contaminated cementum and dentin
8. Following the initial phase of periodontal therapy (i.e. oral hygiene instruction and scaling and root planing), one should wait how long before evaluating its effectiveness:
 - a) 1 to 3 weeks
 - b) 4 to 6 weeks
 - c) 6 to 8 weeks
 - d) 8 to 10 weeks
9. Starting with health, histological changes occur to the gingiva within 2 to 4 days of plaque accumulation on the adjacent tooth. How long must plaque accumulate in an area to produce established, clinical gingivitis in most people?
 - a) 1 week
 - b) 10 to 14 days
 - c) 2 to 3 weeks
 - d) 4 to 6 weeks
10. The best clinical indicator we have to practically evaluate the presence of inflammation and potential attachment loss in a periodontal pocket is:
 - a) bleeding on probing
 - b) increasing pocket depth
 - c) presence of plaque
 - d) clinically visible gingivitis
11. A periodontal pocket is different from a periodontal sulcus in that:
 - a) a sulcus never bleeds upon probing
 - b) a pocket is deeper than 3 mm
 - c) a sulcus is not necessarily healthy
 - d) a pocket is the result of pathologic detachment
12. Chlorhexidine mouthrinses are clearly the best agents for chemical control of plaque accumulation. Which of the following is not a side effect of chlorhexidine use?
 - a) staining of teeth
 - b) dentinal hypersensitivity
 - c) increased calculus formation
 - d) altered taste perception

Submitted by Major Murray Cuff, CD, BSc, DDS, Dip ABP, FRCD, Director of Hygiene and Periodontics, Canadian Forces Dental Services School, Canadian Forces Base Borden, Ontario

Answers:

- | | | |
|--------|--------|--------|
| 10. a) | 11. d) | 12. b) |
| 7. a) | 8. b) | 9. c) |
| 4. c) | 5. a) | 6. c) |
| 1. c) | 2. b) | 3. b) |





Surgical Intervention for Hyperplastic Gingival Tissue

By:
Leanne D. Carlson-Mann, Dip DT, Dip DH

History

Hyperplasia is the abnormal increase in the *volume* of an organ or its parts because of an increase in the number of normal cellular elements. This increase in tissue does not serve any functional purpose. In gingival tissue this overgrowth occurs most often interproximally causing oral hygiene difficulties. The enlarged tissues encourage bacterial plaque retention thus increasing the potential for periodontal infection and/or gingival hyperplasia.

Systemic conditions, especially those that alter the immune system, can influence the severity and rate of development of periodontal

disease, as well as one's healing response. In some cases there is an exaggerated response to bacterial plaque irritants; in others, there is an alteration in the resistance to infection and healing capacity which influences the choice and/or outcomes of therapy.

In most cases, the treatment options include (a) removal of local irritants, during a scaling and root planing procedure, (b) instruction in personal plaque control methods and (c) surgical intervention such as a gingivectomy.

The following local and systemic conditions may exhibit gingival hyperplasia.

1. Steroid Hormone-Influenced Gingivitis

- pregnancy
- puberty
- just prior to menstruation
- extended use of oral contraceptives

Changes in hormonal balances and tissue metabolism may result in an exaggerated response to the presence of local irritants and bacterial plaque.



Top Left to Right (Before and After)
A 13 year old female with gingival enlargement.

Bottom Left to Right (Before and After)
A 12 year old female (puberty gingivitis).



Left to Right (Before and After)
A 28 year old female with pregnancy gingivitis.

2. Drug Induced Hyperplasia

Three medications that can predispose gingival enlargement are:

- Phenytoin (Dilantin: Parke-Davis)
— a drug used to control seizures.
- Nifedipine (Adalat: Miles; Procardia: Pfizer)
— a drug used in the treatment of angina and ventricular arrhythmias.
- Cyclosporine (Sandimmune: Sandoz)
— immunosuppressant drug used for patients with organ transplants to prevent rejection.



Top Left to Right (Before and After)
A 36 year old male with epilepsy on phenytoin therapy.

Bottom Left to Right (Before and After)
A 20 year old patient on nifedipine.

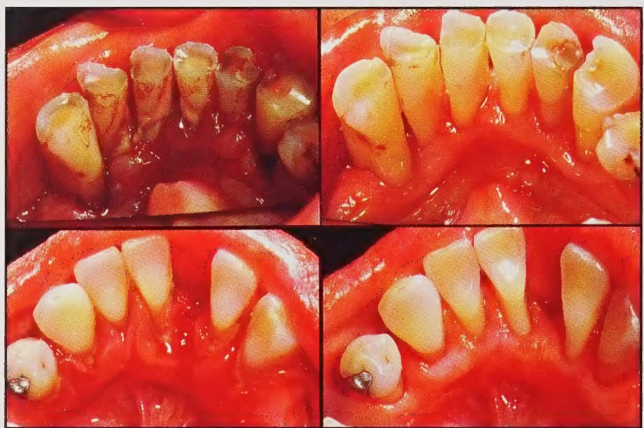


A 40 year old male who has had a heart transplant and is on cyclosporine therapy. The maxillary arch has been treated surgically.

3. Effects of Diabetes

The oral mucosa, tongue, and periodontal tissues of a client with diabetes mellitus may show unusual susceptibility to injury, infection and all local irritants due to a lowered resistance and delayed healing processes. This is especially true in clients with uncontrolled diabetes. Inadequate bacterial plaque control contributes to a more severe tissue response.

It is also important to focus on stress prevention during the delivery of oral hygiene care as undue tension can cause an increase in glycemia and a tendency toward diabetic acidosis and coma. Antibiotic coverage is advisable for clients with uncontrolled, unstable diabetes mellitus or for clients with well-controlled diabetes who exhibit a periodontal infection.



Top Left to Right (Before and After)

Bottom Left to Right (Before and After)

4. Effects of Mouth Breathing and Inadequate Personal Oral Hygiene

Repeated dehydration of anterior oral tissues can lead to changes in size, shape, surface texture and consistency of gingiva. Combine this with poor personal oral hygiene practices and the client may suffer from gingival hyperplasia.



*Left to Right (Before and After)
A 19 year old male mouth breather.*



*Top Left to Right (Before and After)
45 year old male with inadequate home care.*

*Bottom Left to Right (Before and After)
21 year old female with inadequate home care.*

Treatment

In all of the above cases, the individuals received home care instruction, scaling, root planing, and gingivectomies. All clients had adequate attached gingivae and surgery was not performed to correct osseous problems. It was determined that resection of the affected tissue with a gingivectomy knife would not result in any post-operative mucogingival problems. A standard external bevel gingivectomy was performed. No sutures were required.

Note that gingivectomies may not be considered the treatment of choice for all cases of gingival hyperplasia. Often a gingivectomy may be followed by more hyperplasia thus requiring another gingivectomy. Some clinicians may therefore restrict therapy to the more conservative approach involving professional prophylaxes and personal home care instruction.

Case Studies are presented for the interest of our members. However, CDHA is not endorsing any specific interventions.

We welcome submissions of this nature from our members to encourage an exchange of information.



National Certification for Dental Hygienists

By:

Brenda Walker, Dip DH**Dianne Gallagher, Dip DH, BGS, MEd****BRENDA WALKER, Dip DH**

In 1982, in response to a priority concern of members, the CDHA began to investigate a national certification process to enhance portability (the ability of dental hygienists to become licensed in all Canadian jurisdictions) through a nationally recognized credential. By 1984 the CDHA Board of Directors had endorsed the concept of having a single national standard for entry to practice and began investigation of a system which could provide that standard and enhance quality assurance.

As it relates to health professions, certification is an "entry to the profession" mechanism which assures that candidates have met specific standards for beginning practice. In Canada, many professions, among them pharmacy, medicine, architecture, law, nursing, physiotherapy, occupational therapy, medical laboratory technology and dentistry have required mechanisms for national certification. Usually they consist of a written or clinical examination or both. National certification for dental hygiene is now becoming a reality.

**DIANNE GALLAGHER,
Dip DH, BGS, MEd**

Why National Certification?

The objectives of the National Dental Hygiene Certification Board are:

1. To further the public interest by providing a mechanism that reflects a national standard for assessment of candidates for entry into the practice of dental hygiene, and
2. To encourage and facilitate portability of licensure from one dental hygiene licensing jurisdiction to another.

What Does National Certification Mean to a Dental Hygienist?

As verification of having met national standards, certification will enhance professional credibility and stature. National certification will also facilitate portability between participating provinces.

How Long Is the National Certificate Valid?

The National Certificate is a permanent certificate with no expiry date.

Which Provinces Will Recognize National Certification as One of the Requirements for Entry to Practice?

Alberta, Ontario, New Brunswick and Prince Edward Island have announced their acceptance of the National Certificate as one of the requirements for entry to practice in their respective provinces. Approval in principle has been indicated by British Columbia, Saskatchewan, Manitoba, Nova Scotia and Quebec. These provinces must complete amendments to current Regulations and bylaws prior to their official acceptance of the NDHCB certification.

Who Is Eligible to Sit the National Certification Examination?

Graduates from Canadian Dental Association or American Dental Association accredited dental hygiene programs. Eligibility of graduates from non-accredited dental hygiene programs will be determined by the National Dental Hygiene Certification Board.

What Will the Format of the Examination Be?

Part A will be a written examination based on dental hygiene competencies and related knowledge. A clinic examination (Part B) will be developed at a later date.

Will There Be "Grandparenting"?

Yes.

Who Will Be Eligible for "Grandparenting"?

Dental hygienists who are registered/licensed and in good standing, in any jurisdiction of Canada may be "grandparented" upon application and payment of fees. The opportunity for "grandparenting" will be available for a *limited time period* only.

How Much Will "Grandparenting" Cost and How Will Fees Be Collected?

Provincial regulatory bodies will choose between 2 options for "grandparenting".

OPTION 1: Require it as the criteria for renewal of provincial registration/licensure through payment of an additional \$50.00 fee for this year only. The fee would be \$50.00 more in 1995 in order to cover the cost of the grandparenting process. National Certificates would be forwarded by the NDHCB to all registered/licenced dental hygienist in good standing.

OPTION 2: If the Provincial regulatory body does not collect the \$50.00 fee with this year's membership renewals, individuals interested in acquiring a National certificate will have to apply directly to the National Certification Board in Ottawa. The fee will be \$100.00 for the first 6 months that grandparenting is available and will then increase to \$200.00 until December 31, 1995. As of January 1, 1996 national certification will only be obtainable through writing the examination.

RESOURCE CENTRE — NEW ACQUISITION

Book References

Clinical Practice of the Dental Hygienist, 7th Edition,
Esther M. Wilkins, published by Williams & Wilkins, 1994
(one available)
ISBN #0-683-09078-X

How Will the National Dental Hygiene Certification Process Be Funded?

Initial development of the examination will be funded through "grandparenting" fees. Continuing administration will be funded by candidate examination fees.

We urge you to have your province consider adopting Option #1 at the earliest possible time, because:

1. The goal of national certification is to ensure one standard across Canada. It is therefore, most appropriate for all current dental hygienists to be holders of a national certificate. National certification of all Canadian dental hygienists will communicate to the international dental hygiene community, federal and provincial governments, employers, and the public, that there is one standard to practice in Canada.
2. Universal "grandparenting" is the recommended and generally accepted mechanism employed by professions who are introducing a national certification process.
3. Universal "grandparenting" through your provincial registration/licensure renewal will provide a substantial cost saving per member as a result of the use of an already established collection process and reduced administrative costs.
4. National certification fees combined with 1994-95 registration/licensure fees will be a part of your tax deductible fees if collected at the time of renewal.
5. Individual members will be freed from the inconvenience of meeting additional deadlines for submitting NDHCB application.
6. Portability of licensure from one province to another will be simplified. Nine out of ten provinces have indicated their "support in principle" for national certification. Steps will have to be taken by each province to amend regulatory requirements in order to activate acceptance of the national certificate as part of the licensing process.

Your concerns or enquiries can be directed to your registration/licensing authority or:

NDHCB

Dianne Gallagher, Chair

c/o Camosun College

3100 Foul Bay Road

Victoria, B.C. V8P 5J2 FAX: 370-3234



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